MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

Embassy Suites Hotel
1250 22nd Street, N.W.
Washington, D.C.

Thursday, April 29, 1999
10:24 a.m.

COMMISSIONERS PRESENT:

GAIL R. WILENSKY, Ph.D., Chair
JOSEPH P. NEWHOUSE, Ph.D., Vice Chair
P. WILLIAM CURRERI, M.D.
ANNE B. JACKSON
SPENCER JOHNSON
PETER KEMPER, Ph.D.
JUDITH R. LAVE, Ph.D.
D. TED LEWERS, M.D.
HUGH W. LONG, Ph.D.
WILLIAM A. MacBAIN
JANET G. NEWPORT
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
GERALD M. SHEA

AGENDA PAGE

P R O C E E D I N G S

DR. WILENSKY: We started out duly noting our intention to stay on time and here we are quite late in starting.

MS. THOMAS: We're going to be brief. We're going to just go through a quick overview of the chapter first of all and then move to the recommendations, which we would like to take in batches. They lend themselves to that and so we'll put a slide up, quickly review the recommendations, and then you can discuss them and then we'll move on to the next batch.

I would like to point out that we've made some modifications to the draft recommendations that were in your mailings. They're to the first four that were in the mailings on payment, and I think that they're still consistent with the spirit of discussion you had last month, but I think that they reflect a better understanding on our part of the implementation issues involved with moving directly to the development stage.

Tim can address that in greater detail. I've also tried to do a little editorial work on recommendation seven to make those options a little bit clearer.

If you could focus your discussion this morning on recommendations and then we would be happy to try and address any questions and I believe there are representatives of these programs here who can probably also answer any questions you might have, and if you could give us written comments on the chapter today, that would be very helpful.

I'm going to quickly, as I said, review the organization of the chapter. The first section is comparing the three programs, PACE, S/HMO, and Evercare. It reviews their program design, operational features, any results from evaluations that independent HCFA researchers have done, and it also reviews the overlaps and differences between these programs and Medicare+Choice.

The next section moves to the issues of the recommendations around risk adjustment and payment. The third section describes program standards which encompass beneficiary education, performance measures, coverage of non-Medicare benefits, eligibility criteria, enrollment and disenrollment, and the question of the for-profit entities being excluded from PACE.

Then there's a brief appendix on comparing the

benefits in the social HMOs to those in Medicare+Choice and another appendix on Medicaid payments for PACE, which the commission is directed to comment on. Tim is going to walk you through these payment recommendations that you discussed last month.

MR. GREENE: Good morning. We felt draft recommendations on risk adjustment, following on your discussion last time of some recommendation language we had then, we took your discussion last time, the general drift of the meeting and specific comments, combined those with the information we got from the industry and in particular from HCFA risk adjustment analysts, and framed recommendations first the several we sent you and then modifications of them that you have in your hands and that we're presenting here.

We have three risk adjustment recommendations at this point. The first is that the secretary postpone by one year application in Medicare+Choice risk adjusters for specialized plans. This is the point that we made last time, that we're, by this recommendation, supporting HCFA's plan to postpone application in PIP-DCGs to these plans for one year to give the agency more time to collect data and

analyze alternatives for risk adjustment approaches to these plans.

The second would have --

DR. ROWE: Do you want to take these one by one, Gail, these recommendations?

DR. WILENSKY: I was going to have him go through the block, but whatever you would like. If you would find it easier to do it one by one, we can do that.

MR. GREENE: The second would recommend that the secretary study differences between frail elderly and other beneficiaries to identify needs for modifications to Medicare+Choice risk adjusters.

Here we've taken recommendations discussed last time and recommendations from mail-in material, modified it slightly to essentially emphasize research rather than development and understanding cost differences rather than moving to immediate application of new adjusters.

It reflects, in large part, conversations with HCFA where we learned more about implementation issues, implementation costs and problems, and where we heard some useful information about both technical and other procedural issues that made us step back a little back from the more

aggressive tack we've taken in the mail-in material.

The third would have the secretary link payment to beneficiary, not to the plan, and this is the point that was made by a number of commissioners last time, that payment should follow the beneficiary, not the plan, and that any new risk adjustment methodologies for frail elderly should apply to frail elderly beneficiaries wherever they are regardless of the plan type that they're enrolled in.

The recommendation would emphasize also that we realize that implementation issues and implementation difficulties, in particular data availability, might prevent us from applying new risk adjusters to Medicare+Choice plans and might require that they be applied only to specialized plans in the short run.

I welcome any comments or reaction.

DR. LAVE: I'm a little confused about these recommendations and I can understand the order of them. Let me try to explain this. I think that there is a consensus -- this may be wrong, but I'll put it that way for purposes of discussion -- that the Medicare+Choice suggested method as we currently understand it based on diagnosis is not appropriate for the population which is enrolled in the PACE

program.

So that if that is a correct consensus, then I don't understand why we want to postpone for only a year. If it won't work, why don't we want to postpone it until there is something that will work? So that sort of is -- so I started out with a statement that we may not have consensus about, but that was my feeling that we had agreed.

DR. ROWE: We had talked last time, I thought, if I've got this right, Gail, of waiving it for PACE, not delay it.

DR. LAVE: So that would be the question, and I think that we tried to make it -- there is a question in my mind about whether or not PACE and the S/HMOs are different enough that we should consider them. So I don't know whether or not we want to take that on here, but I guess that if we have a consensus or had a consensus that the Medicare risk adjustment program was not adequate to control for a program which dealt with only frail elders, then I think the recommendation number one should be we ought to postpone it until we have done number two and then we can roll from there.

Then I think that once we have decided how we can

develop a risk adjustment for frail elderly, then it seems to me that three, five, whatever they are, they're not in order, that the next ones follow; that once you have developed a risk adjustment that appropriately adjusts for frail elderly, then clearly the adjustment should follow the individual.

DR. WILENSKY: Let me recall, as best I can, but we can have somebody check or you probably have followed it more closely and tell me whether my recollection is correct. We phrased this recommendation the way we did, the first one, because it basically affirmed support for what HCFA says it wishes to do.

So HCFA has taken the position, they wish to have a one-year postponement and that we are saying yes, we think that proposal by HCFA, in and of itself, is a good recommendation. Whether or not in a year they or we will be ready to do anything different I would regard as subject to revision, but it was really saying, as we sometimes do, HCFA has made a proactive statement, we support it.

DR. LAVE: But should we not take it a little bit further and say that the commission believes that, in fact, it should not apply risk adjustment to specialized plans

until they can control for the frail elderly? That, I think, is really what the critical issue is, Gail, is whether or not in fact we think that for plans like PACE, which we know what they look like, they, in fact, can be appropriately reimbursed based on a risk adjustment system which relies heavily on the characteristics of the inpatient diagnosis.

DR. NEWHOUSE: The alternative is 2.39 times the AAPCC.

DR. LAVE: Well, we can revise --

DR. NEWHOUSE: No, no. I'm going to wait in line, but I wanted to -- we've got folks who say what is the alternative.

DR. LAVE: I understand that, but it does strike me, the question that it seems to me is are we better off having a small number of PACE programs that we might be paying a little bit too much money to, rather than having a payment system that is going to put PACE-type programs out of business.

DR. NEWHOUSE: I understand that.

MR. GREENE: The one year delay is framed as a period to allow development of new risk adjustment exactly

for these.

DR. LAVE: But it doesn't say that. I'm going to make a statement. We basically say we then should study the differences and then after we study the differences, we should develop a risk adjustment system. That's not a one-year process, so I'm just sort of saying that -- the question that I'm raising is whether as a commission we want to take the bull by the horns or the goat by the horns or whatever the expression is.

DR. WILENSKY: We may want to just say for at least one year.

DR. LAVE: At least one year and we think that you need to be able to control for frailty before we move ahead.

DR. WILENSKY: Because, in fact, I think you're very correct. The next several recommendations clearly are not consistent with the one-year time frame.

MS. ROSENBLATT: I'm more comfortable with wording like at least one year, because everything Judy mentioned applies to the risk adjustment system for all other Medicare+Choice plans.

I was a little bit concerned with what was in the paper. I'm much happier with the one-year wording at this

point. I'm happier in general with the wording on what was just given out than what was in the paper.

The only other comment I want to make is on recommendation three on the capitation payments, and this may be my terminology again. I think recommendation three is linked to recommendation seven because if we say that the benefits will be different, then the way I define capitation, the capitation should reflect the different benefits. So depending on where we go on seven, we may need to revise three.

DR. WILENSKY: We will come back to that when we discuss seven.

MS. NEWPORT: I'm comfortable with the at least one year piece of this, but I think we all have to understand, in another venue, HCFA has talked about with the five year phase-in of risk adjustment, do they sort of do a cumulative capture of the foregone savings, if you will, and I think part of what we have to understand is when the risk adjustment is implemented on the inpatient side, then we all know there are serious challenges on the outpatient side for the whole program in terms of what risk adjustment should look like for that data. We don't even know what we're

going to have to provide.

I think we need to understand if there's a pent-up savings that would be captured and the possible affect that might be on the plans. I don't know if I've made myself clear, but this has come up before. A delay of one year, is it a delay or does it make that first year of implementation of risk adjustment for this program capture the 10 percent phase-in in addition to the 30. So that's what's happening.

So that may not be what we need to recognize affirmatively here, but it may be a question for further analysis in terms of the impact on these programs.

I just think, let's be clear on the outpatient side. The collection of data is a problem across the board and I think that it's important to capture this and go forward. And I agree with Alice in terms of the linkage with recommendation seven. We need to make sure that they're all congruent as we go forward.

DR. ROWE: A couple of points I was going to make have already been made. I want to associate myself completely with Professor Lave's comments and think there is a dissonance here because you could interpret this as we think that the adjusters are right, but for some other

technical reason, it has to be delayed a year, you know, for implementation. We don't want that interpretation.

I wonder whether we should switch the order of the recommendations and have the first recommendation be study differences to identify, to get the right risk adjusters, and then postpone by at least one year the implementation or something. Maybe that would send a better message, that we need to develop the right technology here and the right approach.

I agree with Janet. I had a question about how this delay relates to the already-delayed phase-in, that program. The other point I would make, which is a general point, and none of my hospitals or health system components, to my knowledge, currently have a PACE program. I just want to put that on the record.

This is a very, very important population. These are the most vulnerable Medicare beneficiaries about which we know the least about providing really good care and it's a really, really small number of people. I think there are 12 of these programs with an average of 200 or something enrollees. We are talking about a very, very small number of the 35 million Medicare beneficiaries.

If there were any way to give incentives to make this program grow or to not to kill this program by over-regulating it or giving it the wrong risk adjusters too soon, we could wipe out what is really a good idea.

I mean, these programs are very small and there is lots of need for them. So from a beneficiary point of view, I think we can -- there are many other things we deal with better, much more greater financial impact on the system than this, so for that reason, I would not put any adjuster in here that I thought was potentially hurtful because what would happen is, it will take us three years to find out that we creamed these programs and then we'll wipe this sort of thing out. We don't want to do that.

MR. MacBAIN: First of all, in keeping with our newfound formality, I would like to agree with Doctors Rowe and Lave.

DR. ROWE: You don't want to necessarily associate yourself with us.

MR. MacBAIN: At least agree with you. Perhaps one and two could even be combined to say that, in effect, let's find something that works first and then implement it. The second point is that there's a difference now, at least

in the statute, between PACE, which is part of the mainstream Medicare+Choice program, and the other two programs. Because of that, I think we may want to look at them differently.

In the case of Evercare and S/HMOs, these are still experiments and it would make sense, in terms of trying an experiment or trying a variety of experiments, to have the payment rates reflect that experimental nature. So tying rates to the programs makes some sense in that context.

On the other hand, with PACE, as now as part of the mainstream, to pay differently for a PACE beneficiary because that person is in a PACE program as opposed to being in a Medicare+Choice program somewhere else raises some issues that go along with recommendation three about trying to pay on the characteristics of the beneficiary.

Having said that, we need to recall that there already is a risk adjuster in place for PACE for frail elderly, so the question is not do we risk adjust, but is that particular risk adjuster appropriate. If so, should that be the same risk adjuster for other people who meet the same criteria in other Medicare+Choice plans, or do we do

nothing for a while until I find a way that works better.

But I am concerned now that if we paid everyone who meets -- if we paid every plan who enrolled people who meet PACE criteria the same way that we pay PACE plans, it would certainly encourage the development of more PACE plans, which is, as Jack said, I think it would, and also, looks a bit more fair in the sense of having the same payment rate for beneficiaries through two different mainstream programs and recognizes that PACE is no longer an experimental program but now is incorporated into the fabric of Medicare+Choice.

DR. WILENSKY: Is that what you're recommending, Jack?

MS. THOMAS: Can I just jump in and clarify for a minute? These distinctions are important, I agree with you. PACE is a mainstream program, but it is separate from Medicare+Choice. S/HMO is on the verge of becoming a Medicare+Choice option. So HCFA is directed to come up with a plan for making S/HMO a permanent option under the framework of Medicare+Choice. And as you point out correctly, Evercare is primarily a demonstration, although it is also a subcontractor to Medicare+Choice plan. So

these are important differences.

DR. ROWE: We've been getting a lot of mail. We get letters and that's fine and good. I think at this point in the discussion, I would find it informative to get the staff's perspective on S/HMO vis-a-vis PACE vis-a-vis both sort of migrating together in our decision-making versus how different is S/HMO than traditional.

DR. WILENSKY: We have several other people who would like to --

DR. ROWE: Or if some other commissioner is prepared to provide that.

DR. WILENSKY: At some point, we may go through these comments. The issue that has been raised in a number of these letters, but also by implication with recommendation three, is what, if anything, are we implying in the short-term for people who look sort of like, more or less like, exactly like individuals who are in PACE or S/HMOs or Evercare, but not in an identifiable exception.

What are we suggesting we do, if anything, and is that something we feel uneasy about. We've already identified that ultimately we think it ought to be the beneficiary and not the plan, but here we are about to make

a specific recommendation.

DR. CURRERI: I think this is a terrific chapter and I compliment you on that. I have one editorial comment, I think, that bothered me a good deal relating to this section of the chapter and it's a small thing, but I think important, and that is in your summary and then again when you introduce this section on Page 12, you refer to the fact that the risk adjustment methods are currently not appropriate for the frail elderly, and this occurs several times.

I kept thinking, I was trying to read this as a person who hadn't seen the chapter before and I kept worrying all the time about where is the documentation for this. We don't get to it until you get to Page 15 and Table F-4, which are terrific.

I wonder if there would be some way either you could move Table F-4 up in the chapter so that we're not worrying about whether this is a true statement or not, or whether you could say, to be discussed later on Page 15, or something, because I found myself worrying so much about that I was forgetting to get the other things in.

I think a reader who has not a whole lot of pre-

knowledge about this would have the same problem.

DR. NEWHOUSE: I'd like to push us in a fundamentally different direction. As I read this chapter, what it says is that there are subgroups in the Medicare population and most particular the frail elderly, but then there are some more stuff in the Gruenberg and Pope papers that were delivered last time, for which the current system or even the current system with diagnosis in it misses badly.

Bill pointed to Table F-4. Sarah has a table -- maybe I should say Tim/Sarah -- F-7 where the frail in communities spend $13,000 a year, the average is four. The nursing home population spends nine, the average is four. Well, these aren't tiny differences.

Judging from the Pope and the Gruenberg stuff adding the PIP/DCGs or the HCCs to this, it's not going to much affect matters. F-4 on ADLs shows that there's problems with people that are severely limited in ADLs. There's big misses with the current system.

There's talk about survey measures, but if we think we have implementation problems with the diagnosis stuff, the survey stuff seems to me worse. I mean, I can

imagine potentially some third party doing functional status, although that isn't going to be cheap, but self-rated health status, presumably, some non-trivial fraction of this population is demented. What are we doing here?

To me, I think more this is a manifestation of a more general problem which you always are going to be able to go through the Medicare population and pick out defined subgroups for which risk adjustment, as we're currently thinking about it, is going to miss by non-trivial amounts.

So to me, this is an even stronger argument for partial capitation which, if the frail in community are using $13,000 worth of services, we'll at least make up some of that difference with billing on partly a fee-for-service basis. I don't think, if we postpone for a year or at least a year that we're ever going to be there with the route we're going down for these populations.

These numbers just seem to be clear to me on that point. I would like to see a recommendation that encouraged the use of partial capitation in particular for these populations, although I would do it more generally for the Medicare+Choice population as well.

MR. GREENE: We had a recommendation in that

direction in our last round and the general feeling of the commission at that point was away from partial capitation.

DR. NEWHOUSE: It was? I don't remember that.

MS. THOMAS: Peter brought up the point of the non-Medicare benefits and how to price them.

DR. NEWHOUSE: Just do it on the Medicare benefits then. I mean, the non-Medicare benefits seem to me -- but I can't imagine that -- we're always going to be looking at numbers like this and we're going to say it's not good.

DR. WILENSKY: I don't have a problem if we want to regard this as a particular example as a general issue with regard to desirability of partial capitation. I don't see it as responding to some of the concerns that are raised here, in part because of what my own views have been of the mix that I would feel comfortable with in terms of capitation versus the direct spending reflection.

So I think a lot of these issues of, does it make sense to think about special adjusters for clearly-identified populations that are in special programs for which you have different eligibility criteria, which I would regard at least PACE as something that meets that.

Now, it may be -- and I've heard sometimes when

you discuss partial capitation numbers like 50-50 or something like that. When I think personally for my comfort level with partial capitation, I'm much more likely to be in the 80-20 world, recognizing the value of having actual expenditures be a component, but not feeling a comfort level of wanting to move in general at least that far away from capitation.

So while I would agree with the thrust of part of what you are saying, that it is hard to imagine a good adjuster that won't leave us feeling uneasy because of these wild differentials, we've not had a lot of discussion about what we're thinking about, and that would at least leaves me uneasy about what that implies for the role of partial capitation or the role of existing expenditures and their importance in Medicare in general.

So either we have to be much more explicit about what weight goes to the capitation and what weight goes to the --

DR. ROWE: Are there any models of demonstrations that provide us --

DR. WILENSKY: Not that I'm aware of.

DR. NEWHOUSE: There are some simulations, but

that's all, because it hasn't been tried.

DR. WILENSKY: As I say, I personally have a high comfort level with 80-20. I am very uneasy about this 50-50 notion and that makes a huge difference.

MS. ROSENBLATT: Recommendation two is saying study different ways of doing it. Maybe we can add partial capitation to recommendation two without attempting to be so explicit now and say do this.

DR. NEWHOUSE: I think that's fine, but if we look at what's before us, basically you can exploit the information on diagnosis, which is the route that HCFA is trying to go. You can potentially exploit survey-based information, meaning functional status or self-rated health status.

Then what are you left with? There aren't really other things on the table to do. So what do we mean when we're going to study it? And then there's big practical problems because while you're shaking your head about the survey stuff, we're doing that. So what are we left with? I mean, I just can't imagine what we're talking about when we talk about another adjuster.

DR. LAVE: There was a question that was raised

and that is, are we talking about -- and we being, I guess, each of us individually, using this applier to everybody or to the people in these programs? I guess my feeling was that I was talking about them for using them with specific programs, and I'll have to say I'm thinking about particularly PACE and Evercare.

Now, PACE does have some requirements to get into PACE. To get into PACE, as I understand it, you have to be certified to be nursing home eligible. So this is something that isn't just sort of a random person coming in. They do have somebody who has come in and whether or not they do it well or whether they do it badly, this person in this program has been classified as somebody who could be potentially in a nursing home.

The people in Evercare are in a nursing home, so they clearly are there. And one of the problems I think with -- that you may want to think about them differently and how bad the nursing home -- the current adjusters is that that program is designed explicitly to keep people out of the hospital, even more so, I think, than the traditional risk adjustments.

I mean, they have people in there watching people,

bringing services into the home. It's very different from, I think, the way that you would treat a community-based program. I feel I'm more uncomfortable about the S/HMO program because as I understand it, it doesn't deal so much with a particular population as with a different set of benefits and it's not clear to me why some of the benefits that they talk about with your geriatric assessments are not things that, in fact, traditional HMOs ought not to be developing for handling the patients who are enrolled in that.

MS. NEWPORT: They have them.

DR. LAVE: That's why I find the breakdown between the S/HMO and the HMO different because some of the particular benefits are benefits that you would think, as Jan just pointed out, some of the HMOs have developed in the context of their organization.

So my sense is that PACE and Evercare are really different and they have been defined in a way that makes them extraordinarily distinct. I guess the question is, in the short term until we figure out how to handle this program, is that something we want to have done. If we get it wrong, it's not going to cost a lot of money for those

particular targeted programs.

So I guess that I think that we're not talking about using this adjuster for everybody in Medicare because we don't have everybody in Medicare --

DR. NEWHOUSE: No, but the issue sits there for everybody in Medicare. I mean, the numbers that we're looking at are based on the Medicare fee-for-service population.

DR. LAVE: I agree with you, but still, on the other hand, we have these people who somebody has come up and put a staple on their head and they have said -- now we can go through and put a label on everybody else's head, but we don't have the technique for doing that. We have not got a method for identifying PACE-equivalent people in an operational sense for overall Medicare program.

DR. ROWE: Are you saying that you think the third recommendation should say something like, within the specialized plans we should link payment to the beneficiary, not to plan type? Are you concerned that that --

DR. NEWHOUSE: No, I'm concerned more broadly. I'm concerned -- I mean, I'm happy to have a recommendation. I agree with Judy's point that we've stamped these people

and it's a small program. Part of me worries that if you look at what's happened to the home health industry, for example, over the last 20 years, that's fundamentally changed because I think largely because of Medicare policy.

I mean, 20 years ago, it was largely visiting nurse associations and now it's largely for-profit industry. PACE is, we're taking 20 new PACE programs a year under current law and that's kind of low and I agree with what both Jack and Judy said about not doing anything that would put these people out of business. I think well of them and I think we should --

DR. LAVE: Once we solve the problem, then PACE would get paid. Anybody in PACE with these characteristics would get paid like anybody who looked like PACE some place else.

DR. NEWHOUSE: I guess my initial reaction a year ago to this was kind of let's just keep this boat going along on the surface of the water and it's small potatoes and we don't want to sink anything and so forth, but what the numbers say to me is there's really actually a big problem with the entire program and that we're dramatically under-paying -- I presume most of these people are in

traditional Medicare, but that the -- Lenny Gruenberg has a number in his paper that people -- that he wants to distinguish, and he's got the numbers to back it up, between nursing home certifiable people who are in nursing homes in a kind of stable way versus nursing home people who are new entrants, as he called them.

The new entrants are 5.7 times the average spending. The stable people are more like 1.4. Now, you can't pay on kind of entry into nursing home or there would be a huge incentive to go to a nursing home. Again, partial capitation is kind of moving part-way in that direction.

DR. ROWE: His assessments show a 30 to 40 percent underpayment even after you add some of these additional things.

DR. NEWHOUSE: No, no, it's much worse than that for this new entrant group. The diagnoses, I think, you're underpaying by a factor of four even with all the diagnosis stuff.

DR. KEMPER: A couple of comments on the partial capitation. I'm very sympathetic to putting that on the agenda. I wouldn't think that these specialized programs is the place to raise the issue, to sort of deal with the issue

for the program as a whole, but I think it's certainly something that would be important to have on the agenda for next year.

I think in doing that, I think the substitution issue is an issue that would have to be dealt with because these programs are, at their very core is the notion of substituting for Medicare-covered benefits other kinds of services like adult day care and specialized physician monitoring and so on.

It's a thorny issue, but I think that, too, is sort of a detail --

DR. NEWHOUSE: That would fit a study-type recommendation. That I could see studying for a year.

DR. KEMPER: Judy, I just wanted to make sure that I understood what you were saying, so let me try and restate it. In the short run, these programs need to be distinct and have special adjusters and maybe the ones they have are okay or maybe they need to be revised.

But in the long run, we want to pay for the individual so that once after the -- assuming we can get something that deals with these functional differences --

DR. LAVE: You've put that perfectly.

DR. KEMPER: The sort of PIP-DCG -- I mean, when we get the encounter data in, whenever that may be, that would be the time to put in -- to have this be part of it.

DR. LAVE: I agree with the philosophy that you want the money to follow the person regardless of where they go. I guess I was reacting to the one-year postponement because my sense is that this problem for this population is more complicated because you've focused it, but you're not going to solve it in one year.

So I objected to sort of in one year and then we're going to study it and we're going to do something. My sense would be that I would prefer us as a commission to say, we don't think we can solve the problem for these special programs with your identifiable people who have been stamped on the head with something or other and that we can't solve this.

This is where we want to go.

DR. KEMPER: In the short run?

DR. LAVE: In the short run. And by the short run, I say a year. I mean, that's basically it. Janet, my sense of this statement was that we were dealing primarily with these special programs, not for the program as a whole.

DR. KEMPER: I had one other point, if I could before I lose the floor. I think there's a fundamental confusion here about the disability measurement, the ADL measurement, and I think it's important to clarify it in the document, but more importantly in our thinking.

That is, they seem to be treated as -- and this is correct -- as health status measures and possibly survey measures. But I think that they are used a lot more clinically than sort of the health status measures. Let me just give two examples.

One kind of health status measure is, do you consider yourself in excellent, fair, good, or poor health, and that's asked of individuals, it's a survey question, and I think quite subjective and subject to manipulation.

ADLs are questions like, can the patient feed him or herself without assistance. Now, that is also a question that has some judgment involved in it, but it's a much more objective question. It's one that can be asked of a clinician and a clinical judgment made about it.

DR. NEWHOUSE: And you could imagine auditing it.

DR. KEMPER: And you could imagine, while it's transitory, potentially, and there are all sorts of

problems, you could imagine auditing it. So I think the functional limitations or ADLs ought to be thought of differently from survey data and some other kinds of health status measures.

In that, they are used for nursing home certification. You can say PACE-eligibles or nursing home certified. Well, those are the kinds of things that are determiners of nursing home certifiable. Correct me, Jack, but I think physicians use ADLs.

DR. ROWE: And IADLs.

DR. KEMPER: And IADLs. So I think if we thought of these as part of encounter data or potentially part of encounter data, that would strengthen the thinking about this and at least be a line toward a potentially feasible way of dealing with this important group.

My feeling is, if it's used like diagnoses are used in payment, in the risk adjustment, reporting systems can be developed to include it in them. For one thing, if you look at the table on the frail population, at least half the population is already getting a service, the payment for which is based on ADLs or will be based on ADLs, home health, rehab, and the SNFs. All of those payments already

use ADLs, so it should be in the records in some form or another.

DR. NEWHOUSE: How do we use ADLs?

DR. KEMPER: Well, SNFs. Home care will, I presume, once the prospective payment goes into place.

DR. NEWHOUSE: We have different expectations about when that might happen.

DR. KEMPER: Right. But I'm just saying that that will necessarily, I think, be based on ADLs to some extent.

MR. MacBAIN: Another look at that partial capitation. It's my impression that with these programs, we're dealing with a relatively small enrollment per plan or per program, and I think a fairly high variance among the enrollees, which makes capitation a poor solution.

You can ameliorate that by a blend of reduced capitation and heavily discounted fees to the extent that it's not as bad a predictor, and that gets me back to the question of, what's the purpose of capitating these programs anyway. Is it to save money or is it to give them flexibility to use capitated dollars to do other things such as finance the fixed costs of a PACE day care facility.

If it's the latter, then a partial capitation also

offers the opportunity to do that and at the same time actually protects the fixed cost investment from being eroded by high variable costs due to the variance and the unpredictability of a small enrollment.

So I think there's a lot to recommend it and I tend to lean more in the direction of a broader mix. I don't know if 50-50 is the right mix and it may have to do with the size of the enrolled population, but I think you want to look at the variance of that population and use that to try to gauge how much do you really want to put on a capitated basis and how much do you want to treat as fees.

DR. WILENSKY: In this particular area, I am not uncomfortable with 50-50 because of the high averages. I'd be very uncomfortable making a recommendation to 50-50 for the general Medicare population.

MR. MacBAIN: You're dealing with a smaller variance there and larger ends.

DR. NEWHOUSE: I'd think we'd want to have some planned variation or experimentation of the general population. I think your point is very good about the small population.

MS. NEWPORT: I think there's so much on the table

here. In order to understand this better, I always do distinguish between PACE and Evercare in the social HMOs, and I think that's sound in one way, but I guess to back up to risk adjustment in terms of what's happening in Medicare+Choice, where some of these functional issues fall is more on the outpatient side. Everyone across the board under Medicare+Choice is struggling with what that data collection will look like.

It seems to me, though, that this criteria falls very neatly into outpatient ADLs and all of the rest. It is a part of a diagnosis effort. So I think that where I would go with this is that we have experience with social HMOs in some areas where they are and they have somewhat unique benefits, but in some ways, that's driven the managed care plans that are already in those areas to do similar things.

So there's been a sort of benefit on the non-social HMO plans to come up with some more unique ways of managing care in these areas. So some of these benefits are not unique anymore to social HMOs, but it does say to me that this demonstration has proven that there is value in expanding the benefits a little more dynamically and a little more on point with what the frail elderly need, and

we need to be a little more consistent there to not institutionalize what we've demonstrated works as something special that should just be in site specific places, which I think we've all acknowledged.

So what I'm looking at is that in some part, when you establish a payment for these folks, I think we have a basis here for going forward that may be embedded in what the data gathering will be anyway on the Medicare+Choice side.

It seems then where I link this up is that if it works, it shouldn't necessarily be site-specific in that okay, you're in this site, so you get X plus Y and that's your payment. If you are that person, we are, in effect, with risk adjustment putting a value on everybody. It doesn't matter. Everyone's going to have that.

So we're just talking about a different level risk adjustment some place. Then the Evercare and the PACE, they are small programs. Maybe they need to be nurtured a little more. We need to be a little more adroit in how we look at those and let these go forward and encourage them.

But I guess I always back up to, at one level, if people move around, which they do, the value should transfer

with them. That's consistent with what we've said risk adjustment is all about. So I'm just trying to struggle with this, understanding the needs to encourage these things, but also let's also recognize at some baseline they're very similar in what we're trying to do for identifying and paying appropriately for their needs. I went around in a big circle.

MS. ROSENBLATT: I'm concerned by what I've heard, that given the short time frame for getting the report out that at least I don't feel right now that we've got consensus among the commissioners and I'm going to make a suggestion that maybe the staff take a shot at altering the recommendations and bring it back to us this afternoon.

I'm going to recommend sort of a compromise. I'm hearing Joe speak very strongly about partial capitation. I don't have problems with that. I do have problems with the timing. I'm real concerned about doing anything for 1/1/2000 because of Y2K problems. I just think there's enough Y2K problem out there that that's going to require new administrations. So I'm comfortable --

DR. NEWHOUSE: I hadn't spoken to timing.

MS. ROSENBLATT: I'm comfortable with

recommendation one, delay one year. That gets us past 1/1/2000. I'm going to again say maybe adding something to recommendation two, that consider using this population as an experimentation for something like partial capitation so you get it in there and expand recommendation two that way.

Then leave recommendation three again subject to looking at number seven.

DR. KEMPER: I think this population is not a good population to experiment with partial capitation on because I think it's a full program issue and we ought to be experimenting on the full program. I mean, the frail elderly are not rare in the Medicare population as a whole. These programs have all kinds of special features which make it difficult to do partial capitation, because they're designed with the objective of dealing with flexibility.

So it's not a small issue to experiment with that. That's not to say I don't think partial capitation is a good idea. It's just not the place I would start.

DR. NEWHOUSE: Well, wait. Not the place you would start if you were going to run a formal experiment of different mixes you mean?

DR. KEMPER: Right. That's what I mean, yes.

DR. ROWE: I think that the important thing, there are two approaches to this we're not hearing. What's important here is the patients or the concept of partial capitation. We need to develop flexible approaches to trying to find better fits to paying for the services for these multiple impaired frail people. I'm open to anything that will do better than what we're doing.

That's my focus. If our focus is theoretically as health care economists or policy wonks or whatever, the concept of partial capitation and where the best place to start it or test it out, that's a very different approach. I think just because you might try it here as one of a flexible mix of approaches to try to cover these beneficiaries doesn't necessarily mean that you have to extend it to other kinds of things.

DR. NEWHOUSE: I was starting from your first concern. I think the second issue came up because of the issue of how partial is partial.

DR. ROWE: Gail sounds like -- and I would support this very strongly, that partial is very different in this population than in the very much larger, less variable

population.

DR. LAVE: I just was wondering whether or not -- one of the things that came out of this discussion -- I'm willing to back off on the recommendation number one. I sometimes sort of like to say what I mean and if we think it's going to be more than --

DR. NEWHOUSE: I thought we said at least one year.

DR. LAVE: Anyway, the issue that we have not talked about here in the recommendations, which I think I heard coming around the table is that we ought to consider adding onto encounter data ADL information. I mean, I don't know. I heard a number of people around the table mention that.

If we are going to start using functional status as part of the risk adjustment system down the road, and if one thinks that that's where one is going, then it strikes me that as people plan the information on the encounter data, that they're going to be including it, that it's sort of silly not to think ahead, but what is the information that is going to be needed on the encounter data to do these kinds of risk adjustments down the road.

If there is a sense that we're going to need functional status, I don't know why we want to have everybody develop huge administrative systems and reporting systems and forms and not have people think about this.

DR. NEWHOUSE: I think that's right, but there is a difference in the data between hands-on functional assistance and just needs assistance that Lenny Gruenberg and this chapter makes. So it's beyond functional status. You need to distinguish those.

DR. LAVE: I guess when we're looking at the differences and we're thinking about what it is that you're going to be requesting has to do in order to make this work, given the discussions that we're having, is there anything in our state of knowledge at the moment that would lead us to suggest that these are the things that plans ought to be considering or HCFA ought to be considering to have encounter forms so four years from now, oh, we can't do that because we don't have the data and we know it's so important.

MS. THOMAS: Can I jump in? As you recall, under the new risk adjustment system there's a need to restandardize the rate book for the diagnoses in fee-for-

service? Well, the problem with going to any kind of data item that's not in the existing data set is that you need that for fee-for-service at the county level. So not only would you need to collect encounter data from plans, but you'd have to somehow get it from fee-for-service as long as the rate book is in its current format.

DR. LAVE: But as long as we're thinking about long term, aren't we just going to have ourselves in a situation where we're not going to --

MS. THOMAS: I did want to make it clear that it's not simply a question of encounter data from plans. You need to somehow go to fee-for-service to get it right.

DR. WILENSKY: At this point, the most we could say to HCFA is that this is an issue that we see coming and when we think about the data elements, let's start thinking now. One of the areas where I'm going to constantly push us is to say, whenever we consider adding, we consider what we're going to take off to keep the overall burden at least no greater if not try to find ways to lessen, because the tendency is every time you stumble on a new problem, you say everything we've ever asked for and now ask for this, too, as opposed to trying to do some kind of zero base.

MR. MacBAIN: To get back to Alice's proposal, which I like, let's see if we can agree on recommending -- agree on postponing for at least a year, in fact, encourage further postponement exploration of partial capitation or capitation based on ADL adjustments or both or something else and hold off implementation until we have enough information from those studies to try to determine what's best.

So put one and two together into one recommendation, essentially saying delay, look at these things, figure out what's best, and then go ahead.

DR. WILENSKY: I don't know whether we've addressed this third issue and what it means for the short run for programs that are not these three thus far identifiable programs as to what, if anything, that suggests in the short term for people who are frail elderly who are not part of this world and whether or not -- I mean, that's, for example, an area where we might want to recommend consideration of partial capitation until we know more about what we're doing.

I think there is a clear sense of concern that there are a lot of frail elderly who are not in these

programs and that while we're protecting these programs, which I agree with, it is not in any way responding to the third bullet which is, we need to do something to acknowledge that it's the person and not the plan that is raising the concern.

So I'm jut a little bit uneasy about what, if anything, are we saying or implying.

DR. LAVE: Isn't that where two leads us? Once we can do it, we get to three and then I guess in three is also where if you do the partial capitation, it would follow also into three, although I think that we've agreed that the issues are somewhat different when you're talking about non-standard Medicare. It's a problem that has to be addressed in designing.

MR. MacBAIN: I think once it's resolved, if I'm running a Medicare plan, enrolling people for whom I receive considerably less than a PACE plan across town that is no longer an experiment but is now my competitor, I think that's a problem. But I don't think it's something we can resolve until we figure out what's going to work for paying the PACE plan in the first place and then we can take a look and see can we build on that to try to generalize the model.

But let's start with a specific model that we've got some understanding about, figure out how to pay them, and then see if we can generalize.

DR. CURRERI: Because you have a PACE competitor across town you quickly build a PACE.

MR. MacBAIN: Depending on what the payment is like.

DR. NEWHOUSE: No, there's a limitation on how many new PACE plans there can be nationally per year.

MR. MacBAIN: Or you could build something like it and if the payment rate is consistent across all plans, then the distinction between PACE and the Medicare+Choice plan goes away.

DR. NEWHOUSE: If it's consistent, sure.

DR. KEMPER: Is this a long-run recommendation or is this an --

DR. WILENSKY: That's really what I'm concerned about, is that what are we implying in the short term? I think in the long term, we want to do something that acknowledges frail elderly wherever they are, whether they're in the currently designated programs or not. But in the meanwhile, are we left with we don't know what to do

with the frail elderly who are not in these programs and until we can figure out, we don't know what to do with them?

DR. NEWHOUSE: I don't think there's anything to do in the short-run.

DR. WILENSKY: Are we explicitly saying that this is among the more important groups to try to consider partial capitation?

DR. NEWHOUSE: That's what these numbers say to me.

MR. MacBAIN: I think it's consistent with our discussion of quality and care at the end of life. It also fits in with other parts of this report to say this is a population that --

DR. WILENSKY: We have not been explicit about that. It is consistent with the third bullet, but if we think that at least in the intermediate term that the frail elderly who are not part of these programs are a particularly appropriate place to think about partial capitation, we ought to say it.

DR. LAVE: Does it make sense to think about partial capitation in terms of one group? I guess if you're going to move towards partial capitation, do you want to

move for everybody or only for the frail elderly?

DR. NEWHOUSE: But I don't think we know the information to answer that.

DR. WILENSKY: The answer is you can't implement it for everybody in the short run, is what I'm hearing back from Sarah because you don't have a way to base the county rate unless you just want to assume, which I can imagine that HCFA would not like to assume, that the distribution of functional status is similar across counties.

DR. KEMPER: The issue you raised about the difficulty and reliability of functional status, information, those are the source of points that the HCFA analysts have pointed out.

MR. MacBAIN: I'm with Peter. I think functional status is in a different category than self-rated health status. In fact another thing you might want to do --

DR. ROWE: In fact the differences are, for those of you -- as many of you probably are aware, this difference is particularly striking for older women, that self-rated health status is better than functional status.

DR. NEWHOUSE: That isn't good news.

DR. ROWE: So that people have a number of ADLs

that are out and IADLs are out and they really look impaired and they're multiply impaired and dysfunctional. You ask them to rate their health and they call it good.

DR. NEWHOUSE: Oh, but the question is, does that better predict the spending?

DR. ROWE: I don't know that. But I'm just saying that these things are not as closely yoked or tethered as one would expect.

DR. WILENSKY: Why don't we take Alice's suggestion and postpone any further in this discussion until we can see your attempt to bring --

DR. NEWHOUSE: Do we want to postpone seven, too?

DR. WILENSKY: Well, we have not talked about seven and I don't know whether --

MS. THOMAS: Do you want to zip through the other recommendations? I think the next set, unless I'm wrong, are pretty zipable.

DR. WILENSKY: It's seven that's the problem.

MS. ROSENBLATT: Can I just make one comment and it's a quick comment about the first one up there? The text -- I'm sorry. Forget it, sorry.

DR. NEWHOUSE: Let me say something. I think

there is a real issue with the self-rated health status as a measure ever.

DR. ROWE: It doesn't work.

DR. NEWHOUSE: Well, I don't know how to audit it, I think it's potentially manipulatable, I mean, as opposed to functional status.

DR. ROWE: I would say the following based on my understanding of the literature. It is not linked to function very well. I can't tell you anything about its linkage to health care costs, but it is, in fact, one of the best predictors --

DR. NEWHOUSE: It predicts, it predicts.

DR. ROWE: It predicts mortality very well.

DR. NEWHOUSE: It predicts spending, too. I still don't think one can -- particularly for this population. I mean, it's one thing to talk about the healthy 65 to 69-year-olds, but this is the frail elderly.

DR. CURRERI: Plus it's hard to [inaudible] --

DR. NEWHOUSE: That's one reason I don't know how we would do it. As I say, for the demented population. I don't know what we do for that.

MS. THOMAS: I have just a couple of things I

wanted to say before you get into this issue. You may keep in the back of your minds that different programs may warrant different approaches on this item of including extra benefits.

On the first bullet where only for the fee-for-service package is mandated is the Medicare+Choice model, the model where additional benefits are required, but no additional payment. For Medicare follows is essentially the PACE model where there's an expectation that this is a program for dual eligibles and there is a small group of people who pay the Medicare capitation amount privately, but in general, most of the people receive the other part of their payment from Medicare.

The third point is the way that S/HMOs have been organized in the past, and you'll want to think about folding them into Medicare+Choice and what the implications of that type of method would be. S/HMOs were not explicitly reimbursed for all the additional benefits that they provided, but there was a 5 percent increase on their base payment amount, which at the time it was created that was supposed to be 100 percent of the fee-for-service amount, no more. But, of course, that is no longer a very helpful way

to think about it since the base payment rates have gotten far away from the fee-for-service amounts in some areas.

DR. NEWHOUSE: I found this a real dilemma trying to think through. I ultimately came down on the first option and the phrase that came to mind was the old phrase out of Vietnam about destroying the village to save it.

If you got in a situation where the PACE plan or whatever plan it was basically wasn't making it on the payment we had, and we know this payment method is pretty crude, then to sit there and insist that it had to provide these other benefits if the alternative was it went out of business seemed to me to be the wrong approach.

Now, in saying that, there is the obvious problem that well, then it really isn't the PACE plan or whatever if it gives up these extra benefits and that is why it was a dilemma. But this was actually the same kind of reasoning, I think, that led Jack and Judy to say kind of keep this small bark afloat on the ocean.

I would go with one, I think the programs, as we know them, would try to do that. I think this is their raison d'etre and that they're mostly committed to this kind of model.

MS. ROSENBLATT: Do we have to say anything?

DR. KEMPER: I agree with Joe on going with the first one for two reasons. One, in the case of PACE, my sense is that the additional benefits importantly come, so to speak, from the Medicaid part of the payment rather than the Medicare part of the payment; that it's really the long-term care.

DR. NEWHOUSE: But money is fungible.

DR. KEMPER: I understand that money is fungible, but that's the adult day care and the help with the functional limitations and so on is importantly for the Medicaid. So that makes that different and in some ways partly a state issue.

The other thing is, if we think of in the long run extending to all Medicare+Choice beneficiaries some of these options, then I think I'd want to stick with just requiring the standard fee-for-service option as some part of it.

MR. MacBAIN: As I understand it, a PACE program or a S/HMO is distinguished by what it does differently; that it has sort of a genetic code that lets you identify this is what it is. Doesn't recommendation one sort of remove all that so that it doesn't have a unique

characteristic, it just has a unique rate of payment?

Eventually, people being people, aren't we likely to see them cling to a unique rate of payment, but not necessarily provide the additional services that distinguish it and qualify it for that unique rate of payment? So I'm concerned about that. I think that there is an adjustment now in place or various types of adjustments in terms of how these plans are paid because they have these unique identifying characteristics and those two ought to go together.

DR. NEWHOUSE: I suppose we could go to something like an exceptions clause like we've done with the exempts and say it's kind of two, but if you're really in dire financial straits, you can apply for some kind of exempt treatment.

MR. MacBAIN: It's kind of like the Defense Department buying an airplane and saying, well, if you really can't produce it at this price without leaving the engines off, then you don't need the engines.

MS. NEWPORT: You can have two programs that do exactly the same thing, one is losing money, one isn't. So you don't have an exception because they happen to be bad

managers. You have to be consistent.

DR. LAVE: One of the questions that I have with respect to PACE, how much of the additional money theoretically goes to PACE because they do different things or how much of the money that goes to PACE is higher because they have what they think would be a very expensive population in a fee-for-service setting?

MS. THOMAS: The 2.39 is based on an analysis of what they would cost in fee-for-service.

DR. LAVE: See, I think that that money -- there's a different reason for the additional payments in the different settings.

DR. NEWHOUSE: But there's got to be big variance around it.

DR. ROWE: From the point of view of somebody who tries to provide the care, the whole point here is that prevent hospitalization and to use the money that would be spent on hospitalization to provide additional services to people who need them which otherwise would not be covered or available. I mean, that's the reason to do this.

DR. CURRERI: So you would like option two.

DR. ROWE: I mean, that's my understanding of the

rationale.

MR. MacBAIN: Somebody said do we have to say anything, and I'm not sure we do.

DR. LAVE: The higher payment is not because of more services.

DR. ROWE: No, but the higher payment is based on the fact that these people with these characteristics have that experience in the fee-for-service which is largely driven by hospitalization, and the key to this program is that it reduces hospitalization and frees up resources for the provider to provide other services. I mean, I think that's the idea.

DR. NEWHOUSE: That's the intent, yes.

DR. KEMPER: That means option one is fine.

DR. CURRERI: No, it isn't fine, because you're not going to get these people out of the hospital if you don't provide those long term care benefits. Non-Medicare benefits are provided like lunches and transportation and so forth.

DR. ROWE: More social services and more home care and more preventive care and what have you.

DR. KEMPER: But if I were a health plan and said

I had to require additional benefits, then I would expect a higher payment for those additional benefits.

DR. CURRERI: You're getting a higher payment.

DR. KEMPER: But you're getting the higher payment because they're most costly patients. You're getting the higher payment and then because you're an innovative program, you're making the substitution of those payments from hospital care to the adult day care and you're doing the same thing on the Medicaid side.

DR. WILENSKY: I think whoever had suggested that we be silent on this issue, I don't think we're ready to make a recommendation. I think this is a serious issue and we ought not force ourselves to comment on this. I would be glad to have us comment on it next year if we have time to think of what it is we believe on it, but --

DR. ROWE: If we keep this up, we'll still be talking about it next year.

MS. ROSENBLATT: That also says that recommendation three needs to have some language in it. If the payment follows the beneficiary and the beneficiary is going from one plan to another with different benefits, then saying that the payment should be the same, I think, implies

number two.

DR. WILENSKY: Or it could imply number one. It is consistent with either of them. Again, it is consistent with the two likely options and we haven't quite decided where we are between those first two bullets.

MS. THOMAS: I do want to point out on this first bullet on PACE enrollment periods the association has made in its comment letter the point that they believe that people in Medicare+Choice plans should be able to disenroll to PACE at any time, but I hadn't explicitly put that on the agenda for you, but it's background information.

The second bullet is something that is in our mandate to comment on. Last year, I think, staff made the decision that we were going to wait to see what the results of the demonstration were, but I did want to bring it back to you in case you thought that those results are going to be so late that you wanted to say something about this earlier.

DR. ROWE: Do we know anything about when those results are going to be available?

MS. THOMAS: The demonstration hasn't started.

DR. ROWE: So not soon.

DR. WILENSKY: Before we open it up, I am uneasy with the first bullet and its totally unqualified position. I would have no qualms about doing what we did for the first bullet, which is to say at the present time, we are not ready to impose the same kind of enrollment as we have.

So postponing the move to annual enrollment for a minimum period of at least a year or something is fine, but I am uneasy with this sort of forever these people can just move in and out at will.

DR. KEMPER: I strongly agree with that. At this time or something.

DR. WILENSKY: I have it at this time, that's fine.

MS. ROSENBLATT: Since that doesn't go in until 2002, do we need to say something at all?

DR. WILENSKY: We really don't need to. I think that whether we want to consider something special for this group is a perfectly legitimate issue, but if it's not a current issue, we don't have to do it now and at the time, I think we ought to think about --

DR. ROWE: The commissioners should be aware that one of the factors that influences enrollment or

disenrollment is related to the states' programs in Medicaid and how rich those programs are and how many services are available, and they vary tremendously from state to state, and if a state reduces the Medicaid program content, all of a sudden a PACE program becomes more attractive to people who otherwise didn't see much difference from being in a PACE versus out of a PACE.

So if you're in a state that has a rich array of programs, you don't really -- well, you've got Medicare and you've got this Medicaid program, so what's the value added to being in PACE, and all of a sudden Medicaid becomes less attractive and everybody migrates.

So a lot of the enrollment/disenrollment pressures are related to things that are not associated with the beneficiary, per se.

DR. WILENSKY: It's really a question of -- I mean, what we're talking about is a number of months. If the state, sometime during the year, made a change, then an individual would have a chance to respond in a number of months thereafter. Again, I think at this point, if we don't have to deal with it because it's not immediately relevant, that's fine. If we did, just to put in a

temporary postponement as opposed to permanent.

MS. THOMAS: Is it your preference where we've taken out recommendation seven to keep the discussion in the chapter or does it make sense to eliminate it altogether?

DR. WILENSKY: I don't have a problem with the discussion.

MS. THOMAS: Keep the discussion, but remove the recommendation?

DR. WILENSKY: Right.

DR. LAVE: Were we supposed to have some information that would guide us on our decision with respect to recommendation number nine? I mean, were we supposed to have something, knowledge about the potential for these agencies? I mean, if one looked at the whole health stuff, you may be kind of suggesting that there could be problems with for-profit entities. I don't know how we can say yes or no.

DR. WILENSKY: Judy, I thought the issue that was raised in the chapter, which I thought was very well placed, is that we ought to have -- it ought to be criteria or performance defined and the issue of what their tax definition is ought not to make the distinction. We ought

to put in performance requirements at whatever level we want, but I would think at least that that is a much more relevant distinction.

MR. MacBAIN: There's more than a tax difference, though. The opportunity for private enrollment in a for-profit is a very powerful motivator, both for good and for ill, that does make it look in some ways a little different from a not-for-profit, particularly if it's publicly traded.

While I agree with recommendation nine, in my mind, it's in the context of having resolved the first issue of rational payment rates that reflect the enrolled population so that you don't get a bad disconnect between what's being paid for and what's being provided.

MR. SHEA: I had a similar thought. I was comfortable with this, but when we decided not to decide the question about benefits and what was going to be required, it seemed to me maybe these things are really linked in the same way that Bill's talking about in terms of the adequacy of the payment rate.

I don't know how you resolve this, but I thought the staff had a pretty simple, straight-forward recommendation in here which, all things being equal, made

sense.

DR. WILENSKY: I think at this point we are being silent on this. Under the special programs, the requirements are as they are with regard to what it is you have to do in order to be PACE or Evercare.

DR. LAVE: We have to make a recommendation on this, right?

DR. WILENSKY: We were asked to.

DR. KEMPER: I guess my question is, why are we running a demonstration of for-profit PACE programs and making this recommendation at the same time rather than waiting until we see what we've learned from that?

MR. MacBAIN: I took it because we were told we had to make a recommendation.

DR. KEMPER: Well, one recommendation could be wait until we see what the demonstration shows, which is where I would come down.

DR. LAVE: It is the logical recommendation given the demonstration.

DR. WILENSKY: I don't have a problem in saying that, although again, I guess I would at least encourage the notion that reliance on performance measures rather than the

for-profit or not-for-profit status seems to be a better way to decide who you want to participate. I feel comfortable saying that in the absence of this information because --

MS. THOMAS: Should we drop the recommendation for now, but keep some of the discussion in there again?

DR. KEMPER: Do we have to make a recommendation, we have to comment?

DR. WILENSKY: We were asked to report back to the Congress.

MS. THOMAS: You are asked, but you can decide to defer that.

DR. NEWHOUSE: Is the recommendation status quo until you see the demonstration?

MS. THOMAS: Do you want to make a recommendation at all or say that we're going to wait?

DR. WILENSKY: The recommendation is to wait until we have the results.

MR. MacBAIN: I think what I hear Gail saying is that we recommend long-term, the focus should be on performance standards rather than corporate structure. We want to see the results. Since there's a demonstration project going on anyway, let's see the results of it.

DR. WILENSKY: Any further comment? I'm going to ask for any public comments before we move to the next session because it's a distinct topic.

MR. SHEA: Just on schedule here, you're going to do the quality section next before --

DR. WILENSKY: Yes. Please identify yourself and try to keep your comments short.

MS. CROTICA: Ella Crotica from the American Hospital Association. One of the things that I felt was important that I didn't really hear discussed is the fact that if you look at just a short-term postponement of movement to the standard risk adjustment methodology, one of the things that happens is you take programs where an alternative risk adjustment has applied fully to their rates and you move them into the transition under the broader-based risk adjustment.

So if you make that movement anywhere within the next five years, you're going from 100 percent of whatever your risk adjuster is, if it's the 2.3 times, and you're going to perhaps 40 percent of the PIP/DCG-type risk adjuster.

It's part of the problem that's associated with

what we do on the upside with risk adjustment for plans that are already identified as having high risk populations because of the needs of the majority of plans whose risk adjustments will take them down.

That, I think, is an issue that is a very cross-cutting issue both for these plans and for the 5 percent of plans whose risk adjustment scores would go up even under the imperfect type of methodology that we have in the PIP/DCG.

MS. SMITH: Marcia Smith from Evercare. Just a few quick comments here. Thank you very much for including the language at least one year because I think we were feeling the same way. We're not going to get to the formula in time.

I would like to bring up that at least 30 percent of our population is in non-demonstration projects, though, and will grow as we continue to grow in Evercare. We will not be demonstration-based, and so the exemption of the demos only does not solve the problem of what do we do with the rest of the Evercare business, which is exactly the same as the Evercare model in the demonstrations.

The open enrollment issue, exempting PACE, I would

submit to you that Evercare should be given a similar exemption. Enrolling only one month a year would first of all deprive nursing home residents of being able to enroll in this program and receive this more advanced primary care, and also because we lose a third of our population a year to death, only having enrollment once a year would cause the demise of the program just because of attrition.

The partial capitation was very interesting. I think that's the first time I've heard that concept and it's certainly one that would be interesting to explore. I do agree with several members of the commission that capitation does give us the flexibility to divert those dollars into other uses.

So I would just be interested in finding out what the percentages would be and what benefit it would be, but still need the capitation at some level to be able to do the work that we do. Thank you.

DR. WILENSKY: Obviously you've not heard many of our sessions with Professor Newhouse if you've escaped the concept of partial capitation.

MR. CARLINER: My name is David Carliner. I'm a founder of Elder Health, which is an organization whose

mission is to serve frail elderly, some of whom live in nursing homes and some of whom don't. We understand the importance of implementing a risk-based payment system for Medicare HMOs and we understand that the PIP system really is just sort of a half of a quarter of a system, but we need to get started.

We're not here to talk about the inadequacies of it for a community-based population, but really with respect to the nursing home population. I know you all have been struggling with during this meeting identified populations which clearly the system is underpaying for, and the nursing home population, I believe, is a segment of the population which can definitely be identified and has some unique factors which make it important to try and create some special exceptions for it.

Many people have recognized, as HCFA itself, as you're discussing, is proposing a delay of the PIP system for Evercare, and what we are asking for is that other people who join managed care programs that are designed for nursing home patients also be able to continue to be paid under the current system until a risk adjustment system which does reflect the cost of nursing home patients can be

implemented.

There are a number of reasons why the PIP system doesn't work for nursing home patients. One of the biggest issues is the one that Marcia just acknowledged which is the death rate. So the whole concept behind the PIP system is to prospectively identify a payment based on past usage, and when we have analyzed our hospital admissions for our nursing home patients, what we find -- their admission into the hospital -- what we find is the people that fall into the highest PIP rates also die typically within six months, typically before there would be any increase in payment for those individuals.

And so, it really is a system that just doesn't relate to the nursing home population.

DR. WILENSKY: I actually agree or have great sympathy with what you're raising. What is unclear to me is whether you have specific implementation suggestions that either we consider or that HCFA considers and perhaps you've shared them with our staff.

MR. CARLINER: Yes, thank you very much. The specific suggestion that we have is that until the full DCG HCC system can be implemented or whatever equivalent system

would be implemented, that people who join a managed care program while living in a nursing home be paid under the current payment system as opposed to under the PIP.

The reason why I suggest that is, if an individual living in a nursing home determines that they want to join a managed care program, they're doing that because there's something special about that program.

So those are all data elements that HCFA absolutely can identify today, that there are no logistical problems being able to identify who those people are, and from the perspective of are they really getting a specialized program, you're allowing the Medicare beneficiary and their family to determine that.

DR. NEWHOUSE: So one variant or another idea that I've talked about in some of my papers that is not mutually exclusive with partial capitation but would go along the spirit would be to say to a plan that you could designate some percentage of your beneficiaries to be reimbursed under traditional Medicare, period.

I mean, maybe 5 percent or something. Now, that may not cover -- there's the problem that some plan may have 10 percent nursing home patients, some may have only 1

percent nursing home patients, but this issue goes beyond nursing home patients, I mean, potentially say a terminally ill patient, this would be advantageous to a plan to do it in that case.

You'd do this kind of in advance. Now, whether you do it annually, whether you do it monthly, I haven't thought through, or quarterly, but there would be some percentage you could, in effect, cede over to traditional Medicare and take out from under capitation.

MR. CARLINER: That actually would not be a helpful solution in this particular case. The way that we operate is we are a globally sub-capitated provider to an HMO and what we do, as Marcia is describing in a very similar fashion is, we put tremendous resources into primary care and prevention well in excess of what Medicare would pay for under fee-for-service.

So, for example, we have a maximum caseload for the nurse practitioners on our staff of 100 patients. Medicare fee-for-service wouldn't support that.

DR. NEWHOUSE: I thought that's what you were proposing. I thought you were proposing that for nursing home certifiable patients, that Medicare fee-for-service

apply.

MR. CARLINER: No, the current payment methodology that's in place for Medicare HMOs is what I'm suggesting.

DR. WILENSKY: To the HMO itself?

MR. CARLINER: To the extent that a patient living in a nursing home has opted into that HMO while they are a resident of that nursing home.

DR. WILENSKY: Only for the person -- not for all of the HMO's enrollees, but only for those enrollees who are in nursing homes?

MR. CARLINER: Correct.

DR. WILENSKY: Maybe we could have some estimate about the numbers involved.

DR. NEWHOUSE: Well, I'm worried about moral hazard on admitting --

MR. CARLINER: If it's a question about how many people would that entail? We believe it's about 15,000 and we could supply documentation for that.

DR. NEWHOUSE: Is that nationally?

MR. CARLINER: Nationally about 15,000 people.

DR. WILENSKY: When our trusty staff is thinking about what to bring back to us for consideration, why don't

you take this also into regard. I know you've had communications. Thank you.

MR. CARLINER: Thank you very much.

DR. WILENSKY: Let us go to the quality assurance in traditional Medicare.

MS. DOCTEUR: You can see I learned at least one lesson from last month, in that I'm wearing black today, on the first day. The chapter on influencing quality under fee-for-service Medicare can be found behind Tab B of your meeting materials.

Let me start out by just saying a few words about the chapter because it is an unusual one. This chapter really is different from other chapters in this report in that it takes both a broader perspective and it, particularly in the first half of the chapter, is at a higher level of generality than some of the other chapters.

I want to explain the underlying rationale for that. You'll obviously tell me whether you like that or hate it, but at least you'll know why I was doing it that way.

There were two things I was thinking about as I wrote this chapter. One is that I thought this chapter

would provide a nice vehicle to capture some of the themes that have emerged in some of your discussions of quality over the course of the past year, and some of the things that I was trying to capture were concerns about comparability across managed care and fee-for-service and our attention to quality, some of the concerns about meeting our objectives for quality assurance while at the same time minimizing the burden on providers, and themes about coordinating with what's going on in the private sector.

There were some others, but in general, capturing themes of discussions was one issue. A second issue was thoughts that it might be very helpful to staff as work on quality issues progresses over the course of coming years to be able to have a framework for analysis for future work.

So if you do agree that these are in general the directions that you're looking for Medicare to proceed in, for example, if we were to go ahead next year and say look closely at the systems for ensuring quality in SNFs, for example, this would provide us a nice way to look and say, well, how far are we from meeting these things and is that reasonable.

So with that lengthy introduction, let me be much

more brief in summarizing the recommendations as they exist now, and I'd like to just highlight how those recommendations differ to the extent that they do from the recommendations that you reviewed in your discussion last month. You can follow along. The first page lists the recommendations.

The first recommendation relates to setting program-wide goals in Medicare for quality improvement. This recommendation hasn't changed substantively, but I did add specific examples of goals that Medicare might adopt in response to some of Jack Rowe's comments last time.

The second recommendation relates to implementing comparable and coordinated quality systems for fee-for-service and Medicare+Choice and the key change here from last time is adding the phrase, "to the extent possible," to emphasize that comparability and coordination should be a general goal, but you want to look closely because it might not always be either feasible or desirable to have fully consistent systems.

The next recommendation discusses Medicare's working with other stakeholders to develop and use common, core sets of quality measures. Here again, the underlying

premise is that Medicare, like other purchasers, is moving to develop quality measures and we want to emphasize that we don't want to reinvent the wheel, we want to work with others and try to minimize the burden on providers here.

Again, this is the same recommendation from last time, but I tried to be more explicit in the text and provide examples in the recommendation language to differentiate between quality improvement goals and measures for assessing the extent to which we're meeting those goals.

The next recommendation relates to testing the use of performance incentives, and this recommendation actually combines two recommendations that you discussed last time and in previous meetings, talking about HCFA's use of prudent purchasing techniques on the fee-for-service side and the use of positive incentives for quality improvement, the carrots versus sticks discussion that you held.

The next recommendation calls for using fee-for-service Medicare quality improvement methods that are used by health plans and purchasers. Again, you discussed this last time relating to the use of best practices and also capturing the idea that HCFA should turn to both private sector purchasers and health plans to try to find examples

of things that are working.

The next recommendation relates to providing consumer-oriented information for comparing both enrollment options and providers. Again, we acknowledge in the text that HCFA is currently working to provide geographic area specific information on quality for use in comparing enrollment options and we note some of the technical constraints in doing so.

This calls for HCFA to look into what can be done to develop provider-specific performance information to aid beneficiaries in making choices about their health care. That's the summary.

DR. NEWHOUSE: Reaction?

DR. LAVE: I have a comment, the first of which has to do with sort of, I think, that it makes more sense to talk about traditional Medicare rather than fee-for-service Medicare. There are a number of reasons, primarily because most of the problems that you discussed have nothing to do with the payment system, but have more to do with sort of the fact that you don't have control over providers and provider networks, which has nothing to do with the way that things were paid. So I think that that's important.

The other thing as I was reading the chapter, I had almost more problems with the text than I had with the recommendations, so I'm not going to say much more. But I think that I was concerned that many of the examples that you had for recommendations did not move us past what we currently do, so it seemed to me it was very difficult to make a recommendation to do what we currently do.

I was wondering, for many of these things, if we ought to be more economical in terms of our recommendations so that we have fewer recommendations that have more substance to them. I did have a feeling that we're getting into --

DR. ROWE: As a clinician, I'm just not going to make it. I don't think that has any special significance, but your CAT scan will be at 3:00 o'clock today.

[Laughter.]

DR. LAVE: I just want to point out that on Page 12, our recommended policy recommendations are the ones that are currently in place and that's what generated that particular comment. We now do influenza and we now do mammogram rates. So those were kind of my generic comments.

MR. SHEA: One of my reflections, after reading

this and thinking about it a little bit was what Judy was just saying, but I ultimately came to a very different conclusion, which is, I thought this chapter serves us very well at this time by pulling together a lot of different things and just working through all the different pieces of sort of what's on the table or what's in play in regard to quality improvement or measurement or consumer accountability in regard to traditional Medicare.

Maybe there are some specific things that we should be putting in here to push forward. I thought of a couple of possible ones and then at the end it probably wasn't new, this is probably just the right level, so I actually liked it quite a bit.

I think just like the last presentation and the discussion, this is really, really good stuff because if Medicare doesn't sort of play a major role in the next couple of years to work on quality, it will really, really be a big problem in terms of any of the stuff that people in the private purchasing side are trying to do.

DR. KEMPER: I also like the approach of laying out the framework and in that sense, it is general and the recommendations are very general, but I guess I agree with

Judy, but maybe for next year it would be nice to go more one level down with more specific recommendations.

I had a particular problem with the recommendation on Page 10. I think it's the third one and it also is the one with influenza and mammography rates. I really didn't understand it and I don't know whether it's a language problem or just understanding, but all sites of care made me think of something that could go across nursing homes and hospitals and physicians' offices, whereas I don't think that's really what I think you're talking about, sort of population-based measures that cut across the whole system.

I found it a confusing recommendation, so maybe the way to say it is to just quality measures that can be used to assess the care provided to the beneficiary population as a whole, or something like that, then across each site of care. I think it's a language comment, but I found it confusing.

MR. MacBAIN: This may be a bit trivial, but because of the MSA and private fee-for-service options under Medicare+Choice, we really aren't just talking about traditional Medicare, to get back to Judy's point. The mode of payment is the issue here and that these folks are not in

organized systems the way that we think of managed care systems, and so we need some other way of trying to measure what's happening.

So I would disagree. I think we need to focus on it as fee-for-service and recognize that it applies not only to the original Medicare structure, but also to the fee-for-service options available under Medicare+Choice.

DR. LEWERS: I think that the statement that Judy made in general I have no problem with the generality, but I think we tend to take some of that generality into our recommendations, which we're not specific enough. You said you don't want to put a burden on the providers, yet your generality would let someone say, well, MedPAC said do this, and yet it could put that burden on it because it's so open-ended. So I think you need to take a look at some of those.

I have a number of things that I'll leave with you, but I was concerned, on Page 5 in the paragraph before establishing accountability for quality, where you talk about the restrictions on Medicare such as a prohibition on constraining beneficiary choice of provider and prohibition on Medicare's interference with the practice of medicine.

That's a big red flag. The public wants choice.

We do not want a program which is going to interfere with the patient/physical relationship. I don't think that's what you mean because later on you clarify some of that, but the way that's said is a huge red flag for the medical community, not only physicians, but other providers as well. So I think you ought to take a look at that statement. That's just so broadly based that it just is inflammatory.

In the recommendation on Page 8, you talk about reducing errors, and I know that the National Patient Safety Foundation, which obviously was established by the AMA but is not solely AMA, it involves a large number of people, they're talking and using the term avoidable errors because errors are going to occur. What we want to do is correct and be able to do something with avoidable errors.

On the same page, at the bottom of the page, you use an example of, health plans might focus on the underuse of ambulatory services, and you're using that in the context of an error. To me that's not an error, and we talk about changing things in here, about the QIOs and QSMICs and their focus and their focus on diabetes.

When I began reading and had to go back and take a look and say, well, are you saying you want them to rechange

their focus? I mean, they pick six and then they pick the ones which are very critical, so I think you need to reexamine whether or not you're really talking about changing the whole structure of organizations that are already operational and programs that are operational.

The other recommendation on Page 10 where you talk about other interested parties, that always bothers me to be that general because we should have a public/private partnership. I've said that probably every meeting, but we're talking about the forum which is not yet formed, it's just still underway, and yet you've got AMAC, NCQA, JCAHO already with their PMCC, I think it's Performance Measure Coordination Council, which is already up and running and we really don't refer to that at any point at all.

So I think that that needs to be in the text or we need to somehow talk about what we really mean by that because it's so broad that we're leaving the door open tremendously.

The other recommendation you talk about on Page 13, the demos and payment, as Gail had said earlier, if you're going to pay it, where's it coming from, we're talking about bonus money and I'm assuming that if we're

going to pay bonus money, the only place you can take bonus money is to take it away from someone that isn't performing.

So I'm not sure where that's going to come from, I'm not sure what you meant by that. If someone is at the upper end on preventive measures, mammograms, we give them a bonus? Does that mean if you're on the other end, you take money away in order to pay for that? So I think some clarification needs to be made on that.

On that same page, you talk about Medicare increasingly has the ability to distinguish among poor performers, adequate performers, and exceptional performers. I'm not sure they do. If they do that, I mean, they have a lot of data, but do they have the ability to actually distinguish? So I think you need to clarify some of that or at least point out what you mean.

I have a few other areas. I'll just give you my chapter at the end and let you go into that, but I'm concerned about what I see as the general nature you started off with, but a lack of specificity in some of these other areas and statements which basically I don't know that we can back up, and statements also that I think are inflammatory without actually supporting data to say that

they're correct. Other than that, I like it.

[Laughter.]

MR. SHEA: And the answer on the incentives. It's a new world. Watch it, Ted, it's a surplus.

DR. ROWE: You're in that old paradigm.

[Laughter.]

DR. CURRERI: I liked the chapter very much because I think it does summarize what's going on right now and I congratulate on that. I think the one place that I thought needed more emphasis, and I'm not sure whether it's for this year's chapter or your next year's chapter, but I was impressed when you mentioned that for the HEDIS, the cost of getting data for HEDIS costs somewhere between $70,000 to $500,000 for a single dataset.

It seems to me that with all these quality things that we're talking about here, there's going to be an enormous cost in terms of data collection and we make no comment in here as to what the commission might think the priorities are. I'm not sure whether we're talking about fee-for-service or we're talking about plans. I'm not sure. There must be a breaking point when the administrator burden gets so great.

I think that the commission needs to give some thought as to priorities for data collection and at the same time maybe taking some of the other administrative burdens away that are also very costly but aren't being utilized very effectively.

I was kind of disappointed that you didn't get into that, but maybe it's too early.

MS. DOCTEUR: Let me tell you, I have been thinking about that quite a bit lately. I was planning to bring you something for the retreat because I think this is an issue that you might want to just focus on in your work next year because it's critical. It's a fundamental issue that requires a lot of careful study and I think it's an area where you could possibly weigh in with some very useful recommendations.

DR. WILENSKY: Beth, I enjoyed reading this chapter. I thought it pulled together a lot of issues that we've talked about. The only general concern and I'll give you one or two examples, although I think Ted has indicated is, whether there are parts that are so generalizable as to not give us some guidance about specifically what do you mean or how would you implement it.

I did notice the interference in care issue as one that I agree is likely to be inflammatory. It may be useful to just remind people a little bit about where that phrase came from. It was part of the initial adoption of Medicare. It was done to reassure the medical community that the Federal Government wasn't going to intervene in precisely how they were practicing.

We're really moved to a different era now in terms of what we're trying to focus on in terms of error reduction and setting up some systems that will lead to fewer errors, make it harder to commit errors because of the processes that are in place.

It may, for some individuals, raise the specter of interfering in the practice of medicine. We are really talking about a very different type of issue, just so that you put some sensitivity around words that were there because they inflamed passions so easily.

Another suggestion that I had, it came up both in the specific recommendation and then in the discussion, was to be sensitive to what is usually only the use of preventive measures as a quality indicator and to not at least explicitly raise the point that we need to be as

vigilant in quality measures and sophisticated invasive care and this common practice of looking only at issues like mammogram rates or vaccination rates for the under-65 population as indicative of quality because it's easy to get out of people's records is really a problem.

It's not to suggest that use of preventive care is not one measure of quality of a health care plan, but something that I think probably many people will be very concerned about is what do we know about what happens to the real sick people, and that is not going to come out there.

DR. ROWE: In that respect, Gail, if I could make one comment, I thought there was an opportunity here, Beth, and I thought this was terrific and I thought you took into account a lot of what you weathered last month.

One of the problems in our reports is that they tend to be not always connected to different chapters. It's nice for us to group them and connect them more. In the chapter we'll get to on care at the end of life, there's a nice little comment about how Meperidine should never be used in pain control, and therefore the use of Meperidine with the brand name for which is Demerol, at least one brand name is Demerol, would be a marker for poor quality care.

So there's an example of the kind of thing I think Gail is talking about where there are some pretty easily identifiable markers for relatively poor quality that go beyond health promotion and disease prevention initiatives.

Maybe if you made a statement with respect to that as an example and you referenced that chapter, it would help the reader tie together something. I think that's what Gail is saying.

DR. CURRERI: In fairness, she did like the use of aspirin after heart attacks and the use of beta blockers and so forth which are positive measures.

DR. ROWE: Those are positive measures of quality. I was thinking of negative measures or something that pops up and you say this is a measure of poor quality.

DR. LEWERS: I think, along Gail's line, as well, a lot of this is claims data. Mammograms are easy to put on a claim because they're there. There are a lot of quality measures that are done by physicians in their offices such as eye exams on diabetics that you don't see that on a claim. So how you're going to determine that and use that as an example, we've got to be very careful how we isolate that.

MS. THOMAS: Right now they mine the medical records and that's what makes the quality measurement so expensive.

DR. LAVE: The other issue that I thought is the fact that what is in this chapter actually links to some of the subsequent chapters and you don't really point out that linkage, I think, well enough. In particular, the ESRD chapter is almost all about quality measurement of a very different kind.

A lot of the error in the autopsy stuff is really -- I mean, they really are all about the same issue and I think you want to keep it in separate chapters, but I think the introduction of this could relate to that because there really is a lot that is going on.

The other issue, and maybe we'll hear about this later, is that there's a lot of deeming that goes on and I'm not sure, for instance, on the conditions of participation. I had thought that if the hospital passed the JCAHO accreditation, it was deemed to meet the Medicare conditions of participation. And there have been other issues of deeming that have come up like the nursing home is one to be deemed. That was a big issue a long time ago when they said

no.

I read all the stuff about the JCAHO, but I have no idea here how many of the hospitals actually affect those higher quality things. This is absolutely wonderful that Medicare doesn't do this, but it turns out that 95 percent of the Medicare hospitals meet that. That information is missing.

MS. THOMAS: There's a complete section of enforcement that's missing that I had at one point and I just decided it was making the chapter -- not adding to the chapter. Maybe I'll put a short reference to it.

DR. WILENSKY: Exactly. So that people aren't left with a question, what people don't always understand, I think we had gotten into this last time, is that when HCFA deems a group, what it does is, in very detailed manner, review how the other group qualifies, and it has to at least meet what HCFA would have done in sometimes greater standard. So it's not this delegation.

DR. LAVE: No, but that was why we talked a lot here about how great the JCAHO and the Medicare is not as strong, but it turns out that I believe that most of the hospitals, I would guess, that meet JCAHO accreditation, and

we don't sort of say that there, that HCFA deems this. I don't want to -- this something sort of sounded like Medicare didn't care.

DR. WILENSKY: Any additional comments?

MR. SHEA: I thought Bill's question about the cost data and Beth, your answer, was on target in terms of our really needing to look at this. When we do, I think we also need to look at not only the cost of measuring and reporting and so forth on the provider side, but also the cost of doing it right on the consumer side.

We've talked about this before in past years. I think we ought to look at both of those things because both of these are big issues and big problems, frankly, but I think in some cases, they get distorted in public debate, oh, it's such a big problem, we can't do anything.

DR. WILENSKY: Further comments?

Any public comments on this session, since we had taken them on the first, and then we're going to do our break and start up after lunch with the chapter on renal care.

MR. KAPLAN: I'm Alan Kaplan, a lawyer in Washington. I've followed the evolution of the Medicare

quality assurance programs for many years back to the original days of the PSRO program. Just a few comments on the chapter.

On Page 4 on the history of quality assurance, I think it would be advisable to start with the PSRO program and go through the changing incentives that led to the different -- incentives in the Medicare program that led to the different operational aspects of the quality assurance effort.

PSROs came in at a time of great concern of over-utilization, did a lot of concurrent review, retrospective denials. It changed in '82-'83 with PPS and a great concern about premature discharge and other short-changing of care and now we have the great move towards continuous quality improvement. So I think just broadening out the section.

On Page 18 on grievances and appeals, without getting too specific, I think the language there is not entirely clear on internal and external appeals in managed care and traditional Medicare and it just, I think, ought to be revisited just to clarify it.

Page 10, there is a reference to greater encouragement of hospital participation in the PRO and QIO

activities. I think that's a very good suggestion and I think the program would benefit from that.

I'd just like to follow up briefly on the earlier comment about the red flag issue on Pages 5 and 6. I do come away with a sense of a -- that the paper is conveying a negative approach to quality in the traditional Medicare as opposed to putting it in the context of double-edged swords and tensions between the issue, for example, of accountability for population and accountability for individuals.

I think from the patient's point of view, choice is still a very important element and the fiduciary relationship the doctor and the patient, however eroded it has become, is still a factor that I think plays an important role in accountability and in quality assurance.

Doctors have a fiduciary relationship to a patient. A health plan has a fiduciary relationship possibly to a population. There's a tension there and a double-edged sword. One is not necessarily better than the other and I think the paper does make some strong value judgments here about what is better in terms of quality assurance.

I would urge revisiting the language on Pages 5 and 6. Thanks.

DR. WILENSKY: Any additional comments? We are going to break now. We will reconvene at 1:15 and we will start with the quality of care for beneficiaries with ESRD. I apologize if there is anybody here who was waiting for that session before lunch.

[Whereupon, at 12:24 p.m. the meeting was recessed, to reconvene at 1:15 p.m., this same day.]

AFTERNOON SESSION [1:27 p.m.]

DR. NEWHOUSE: We're going to start with improving quality of care for dialysis.

MS. RAY: Good afternoon. Included in your mailing materials is a draft chapter on quality in dialysis care. This chapter includes discussions of adequacy of dialysis, anemia, nutrition, hospitalization, and mortality. Additionally, the chapter also provides information on current quality assurance and assessment projects.

I'd be happy to address your questions that you may have about the text of the chapter during our discussions of each recommendation and I will now go ahead and proceed with those recommendations.

The first recommendation recommends that the secretary explore the feasibility of a composite rate with different payment levels based on the frequency and duration of hemodialysis prescribed. Duration of dialysis is one aspect of adequacy of dialysis.

This recommendation is centered on looking into the feasibility of increasing the length of dialysis for those individuals who may need longer or more frequent sessions by creating multiple payment levels.

DR. NEWHOUSE: I'm wondering if we shouldn't discuss these as we go.

MS. RAY: As opposed to all of them?

DR. NEWHOUSE: That's right. So why don't we see if there's any reaction to this recommendation or is everybody comfortable with it? I'll assume silence implies consent.

DR. LEWERS: Wait a minute. Thank you. I had to find my notes. Everybody else is looking at Page 9. I think the only question I had was, we're isolating here on two factors, the frequency and duration, in other words, paying different levels based on frequency and duration.

If we're going to isolate out just two elements, there are more. If you get frequency and duration, then perhaps you get better KT over V URRs, but if you're going to base payment -- and I have no problem with a multi-tiered system -- if you're going to do that, should we in some way change this recommendation to include some of the other factors such as a URR over 65?

I hate picking numbers because those numbers change with time, but I just was curious as to what your thoughts were, why you picked just two.

MS. RAY: The second sentence of the draft recommendation goes into exploring the specific clinical criteria. I did not feel comfortable being that specific as to picking a specific URR or KT over V.

DR. LEWERS: The reason you go on to the specific is that you're saying you could add that to that as far as the multi-tiered system?

MS. RAY: Exactly.

DR. NEWHOUSE: I might do some wordsmithing to make that clearer.

DR. CURRERI: I object to the word explore because I think we should say the secretary should determine the specific -- something of that sort. Explore to me means that you explore it, but if you don't have some specific clinical criteria, you're going to have a real problem with gaming, I think.

MS. RAY: I agree with you and again, that was where my second sentence came from.

DR. ROWE: Nancy, let me see if I understand what this is meant to indicate. That if somebody with short dialysis, and you mention in your chapter three-and-a-half hours is average or something like that, somewhat less than

four, does not have a urea reduction ratio that is over 65 or KV over T or whatever that is in what we would call a satisfactory range. Then that person become eligible for extra payments associated with their dialysis should their dialysis be extended beyond this shorter three-and-a-half to four hours. That's the point, right?

MS. RAY: That is correct.

DR. ROWE: So we want to prevent places from getting paid for giving long dialyses to people who don't need them, right?

MS. RAY: Yes.

DR. ROWE: And give them an incentive to give people longer dialysis who, in fact, do need them? But we don't want a lot of three hour and 31 minute dialyses, right?

MS. RAY: That's correct.

DR. ROWE: So maybe what we need to do is rewrite this to indicate -- you could almost -- I guess it's okay the way it is. I'm just thinking the second sentence should be first and that is, what you want to do first is identify those people who are not getting adequately treated with the current duration or frequency of treatment and then for that

subset of people, you want to have a composite rate that permits a facility to get paid more to provide the additional needed treatment.

So I think doing it the opposite of the way you do it might be more clear.

DR. NEWHOUSE: Let me ask about that. Suppose this person is not getting adequately treated and the higher payment for additional duration kicks in, how long does it stay, forever?

DR. CURRERI: Until the patient comes back.

DR. NEWHOUSE: You don't want to -- suppose the patient, to stay down here, needs four-and-a-half hours.

DR. ROWE: No, no. I think that clinically, and Dr. Lewers is the nephrologist here.

DR. NEWHOUSE: That's why I'm asking it.

DR. ROWE: I would think that clinically --

DR. LEWERS: I'm going to wait and see what he says.

[Laughter.]

DR. ROWE: -- patient's clinical state changes, Joe. If somebody has had a major acute illness, major surgery, certain nutritional interventions, their

requirements for infection, whatever, requirements for dialysis, had a heart attack, had some failure, may be greater for some period of time, but not forever.

DR. NEWHOUSE: That's what's motivating my question.

DR. LEWERS: There are basic prescriptions that you're going to calculate based on the size of the patient. You know, a frail elderly lady does not require as much dialysis as someone who's a linebacker for a football team. So in that sense, you do have basics. But then the parameters, you know, that were discussed change over time and you may have to change that formula.

But I think what we're talking about here is establishing some way to make sure that this is accomplished. There are problems with this and the reason I'm comfortable is, we change the word explore. Evaluate it. One of the areas that I would think, and I know it says so in the text and I questioned whether we ought to put it in here, is that a lot of this work is going on now in the community.

So I would hate to see the secretary take off on a total tack without communicating. I happen to know that

HCFA is working very closely with the Renal Physician's Association and a few other groups in trying to improve these parameters.

I would like to see us reference that somewhere in at least one of our recommendations and working with the physician community in doing that. As a matter of fact, I even wondered -- I'll put it in here now, Joe, I was coming back to it later.

I really wondered if we needed a recommendation on that, you know, the secretary in some way dedicate funds to work in the develop in the quality arena. Just to focus on the quality is something we've talked about here ever since MedPAC has been involved.

So I was wondering if there ought not be another recommendation just isolating out the quality component and working with those entities. I don't like renal community, we've used it repeatedly and I'll talk about that in a minute, but it may be the best term.

There are a lot of people working in this area and I would like to see the secretary working with it and taking some of the funds that we perhaps could direct into this. I even come strong enough in the one area where you say should

be developed in collaboration with the renal community. I was going to put must, but I don't know that I could.

Knowing that they're already doing it, I'm comfortable with this. I think they really are working hard at this and I would like to see them continue it and I think we need to support them as best we can because of some of our other recommendations.

DR. NEWHOUSE: I'm still confused about what we have in mind for payment policy. That is, I understand that if the URR doesn't get down far enough, then we would kick in and we would pay additional amounts for additional time on dialysis. At least that's how I understand it.

My question is, does that go on forever? Does it go on for another year? Does it go on -- is there any -- what do we have in mind? I'm just asking for clarification.

DR. LEWERS: We discussed that last month. We had some comments last month.

DR. NEWHOUSE: What did we say? I have a short memory.

DR. LEWERS: We said that was one of the problems with the multi-tiered composite.

MS. RAY: But If I could intervene just for a

moment? At least how I envision this concept, it would be based on clinical criteria almost parallel to how payment for erythropoietin is set up based on --

DR. NEWHOUSE: So basically once you came into compliance, you go back to a non-multi-tiered rate?

DR. ROWE: No, because the only reason you have a URR that's good is that you're in dialysis and as soon as --

DR. NEWHOUSE: That's exactly why I asked.

DR. ROWE: You're in dialysis and you go back and --

DR. LAVE: I have a question, Joe. I mean, it seemed to me that this is a perfect case to think about the marginal costs of additional dialysis. If you get the marginal payments reasonably correct, then you shouldn't be too concerned about the provider incentive continuing to be too much for financial as opposed to patient-related issues.

So you have the incentive that you can figure out, and I assume it's a feasible problem, sort of on average how much does it cost to keep this going on the margin, then the concern, as I read this, is not so much that you now have the incentives aligned up for the units.

The problem that remains, which probably provides

some countervailing authority if you're concerned about going overboard, is the fact that this is not a pleasant procedure and that the patients are not going to want to have longer -- that there's no incentive for the patient to be longer if he doesn't think he or she is getting better.

DR. NEWHOUSE: I was actually worried about the problem Jack raised, that you could have this patient kind of cycling up and down. But I could be assured that that's not -- if you want to tell me that's not going to be a problem --

DR. ROWE: I don't think anybody is assuring you. I think the closest you could come is you could pick some period of time in which most of the transient or reversible causes of an increased dialysis requirement might be expected to be resolved. That period of time is not three years. It's probably six months or something like that.

DR. LEWERS: More or less.

DR. ROWE: But you would have somebody like Ted suggest a period of time and you would say that after that period of time on this level two or whatever it is that we're going to call it, then the patient's eligibility would have to be reviewed or something like that, or annually

thereafter, or something like that. Does that make sense?

DR. LEWERS: I think there's another element that we talked about the last time. While it's still not clear, but even falling in this would be some rate for the daily dialysis.

MS. RAY: Yes, I actually --

DR. LEWERS: This is another element and if that pans out, there should be a rate that should be determined. I considered that all in this one recommendation.

MS. RAY: Yes, as I have also, yes.

DR. NEWHOUSE: Maybe the recommendation needs to be expanded or supporting text needs to be there because --

DR. LAVE: They have frequency and duration both in the recommendation.

DR. NEWHOUSE: I was left with a lot of questions about what we actually meant for payment policy. It was just vague. The principal seemed all right.

DR. LEWERS: In the same example, you bring up erythropoietin. When erythropoietin started, they put a hematocrit of 30 and once you got above 30, they cut everything off. So we played ping-pong all the time trying to establish the right dose. Now they're up at a more

acceptable level, but how long did that take to get there? That's the sort of thing that I think we're worried about, and we might try rewording this to try and include some of those things.

DR. LAVE: I guess the question I have that I have, which is the more significant problem or the equal problem? One of the duration of the dialysis or what of the frequency of the dialysis?

DR. LEWERS: Yes.

DR. LAVE: They're both equally --

DR. LEWERS: No, it varies. We've gone through a whole sequence which we said if you dialyze more frequently for a shorter period of time, individuals do better. And then there are programs and there's some good evidence to show that what you pull off, if you want, the toxins takes time and if you look at what you pull off very quickly, you need to pull it out of the cells into the system, into the vascular system and then pull it out through the kidney itself.

So you've got to balance all of that and you have to do that with time. It's not a simple one more than the other.

DR. LONG: To follow up on that, we've got a patient worth three-and-a-half hours into this and we do not have whatever our satisfactory criteria numbers are. Does that mean that we don't turn off the machine or does it mean you come back tomorrow morning?

DR. ROWE: You get that back a week later.

DR. LEWERS: You don't know that. You'll know that later than that. You'd only know this over a period of time of what the adequate dose will be. You can calculate that basic dose, but then the other parameters which aren't as specific and can't be determined, you've got to do that over time and adjust the dose accordingly.

DR. ROWE: So it's like a prescription you write for the next month, this is how we're going to do in the next couple months, not the next hour.

DR. CURRERI: Ted, would it be fair to say, though, to answer Judy's question, that the marginal costs are less with prolonged dialysis as compared to more frequent dialysis because you have all that nursing time, taking care of the machine?

DR. LEWERS: I don't know that you can say that in today's world where we're looking at this daily dialysis or

more frequent dialysis. Lowering the need for epo, lowering the need for medication, non-hospital exposure or hospital admissions. All of those are changing in some of the studies that are showing the more frequent of the dialysis. There still has to be a certain time period.

We went through a phase where high-flux dialysis, in other words, very high flows with a very porous membrane was going to be the answer. We could bring people in, put them on for an hour-and-a-half and they'd be fine. Well, that didn't work out. There are still some people who feel that way, but that's not the answer.

DR. CURRERI: But for my education, is it the total time that they're on dialysis or is there -- in other words, if I have somebody on dialysis three times a week for four hours each time, which is a total of 12 hours, or I have them on six days a week for two hours, would that be equal or are there differences?

DR. NEWHOUSE: Do you mean from costs or outcomes?

DR. CURRERI: From clinical outcomes or maintenance control or whatever you want to say.

DR. LEWERS: I think that the clinical outcome, depending on if you're saying six days a week short-term

depending on blood flow dialysis dosing, is probably going to be, if you were doing it for a short period of time, an hour-and-a-half versus six days a week is probably -- it's going to cost you more depending on where that service is provided.

There are a number of variables. Probably no better than three times a week at four hours. But there are individuals who are doing low flow dialysis for eight hours and doing that more frequently and showing that they're getting a more and better product at the end. So it's not a simple thing.

DR. ROWE: I think it's important also to understand that there are a lot of patient-related characteristics which influence this more so than the physics, if you will.

DR. CURRERI: A lot of people can't stand eight hours at one time.

DR. ROWE: For many patients, it's not convenient or feasible for them to come six days a week or the transportation costs wind up to be more than the dialysis costs or if they're diabetic and they have neuropathy, they crash four hours into the dialysis and get low blood

pressure and a variety of events which are very adverse.

There are many, many patient-related characteristics, some medical and some not, some social and others, and we have to be able to provide the providers with a level playing field so that they can give a prescription that meets the patient's needs without major financial incentives or disincentives to either give longer dialysis or more frequent dialysis. That would be wrong.

I mean, we have to be able to match the treatment with these patients.

DR. LAVE: It seems to me, Joe, that the recommendation that we have up there is about as detailed as a lot of recommendations that we give, and what it says, as I read it, is that the current compensated rate is extraordinarily inflexible with respect to the needs of the patient and isn't designed towards giving the better way and there are better ways of doing it so go work and think about it.

DR. WILENSKY: This may have been discussed before I came in. I was out talking about Commonwealth Funds Task Force on Graduate Medical Education. It ran a little longer than I had anticipated. But the two sentences seem a little

disconnected. I support the notion behind them, but I was concerned that the second sentence and the secretary should explore in that the reason or what you would want to have the multi-tiered composite rate so that you would have differential payments, but you would want it tied to different --

DR. ROWE: We're pleased that we're thinking along the lines that --

DR. NEWHOUSE: Great minds think alike.

DR. ROWE: We're pleased to hear that we're thinking along the correct lines.

DR. WILENSKY: It's taking a long time to reach that.

DR. ROWE: But shorter than usual for me.

DR. LEWERS: That's because he's sitting next to me and I had to keep telling him what to say.

DR. LONG: How do we pay for the transportation costs, or do we?

DR. LEWERS: We do not.

DR. LONG: Because I've got one of these free-standing dialysis centers around the corner from me and all day long there's this steady stream of ambulances, handi-

cabs, and vans with lifts that are run by professional companies. Who's paying for that, because a lot of those patients don't appear to me to have the means to pay for it.

DR. NEWHOUSE: Maybe Medicaid?

DR. LEWERS: The state programs, county programs generally do that. As far as I'm concerned, I don't think Medicare pays anything for that.

DR. LONG: So increasing frequency would visit significant costs on other programs?

DR. LEWERS: Yes.

DR. ROWE: I like the way this is worded, also, Nancy, with respect to Joe's question about not only the initiation, but the continuation, because what you just have here is you say, for patients to qualify for increased frequency and duration.

It's ambiguous. You can put in the narrative that there would be a concern about not only the initial qualification, but the capacity to continue. The way you have it is ambiguous with respect to that, so I think that's all we really need to say.

DR. LEWERS: I'm comfortable with it. I think there are problems that are going to develop. For instance,

we sit around this table and some sit here the whole duration of the time. Others of us get up and stand around and walk around.

Patients are the same way. Basically getting someone to sit still for four hours, no matter how comfortable the chair is, is exceedingly difficult. If we're going to say, okay, in order to get more money for this dialysis patient, you're going to have to sit there five hours, you're going to have an increase on compliance. So I think those are problems they're going to run into, but that's something that we have to work out.

That's the point I wanted to make earlier about working with the renal physicians, the RPA, et cetera, in an attempt to try to work through this problem. There are a number of problems associated with this, but I don't know how to write it in a way that's going to encompass all of that.

DR. NEWHOUSE: Are we through discussing this recommendation? Nancy, do you have everything you think we need?

MS. RAY: I have everything.

DR. NEWHOUSE: Okay, back to you.

MS. RAY: The second recommendation reiterates our recommendation from the March 1999 report calling for a 2.4 to 2.9 percent increase in the composite rate.

DR. ROWE: March 1999? That was last month.

MS. RAY: Yes, that's correct.

DR. ROWE: Didn't we recommend this last year?

DR. LEWERS: Yes, in March of '98.

DR. WILENSKY: But we also recommended it last month or in March. We did both.

DR. LEWERS: I think we ought to somehow word this to include what --

DR. ROWE: To send a message that not that they didn't do last month's recommendation. We should send a message that they didn't do last year's recommendation, is what I thought the purpose was.

DR. WILENSKY: I think we definitely want to, in the text, indicate the importance of the payment rate increase, which was included in our '99 report and our '98 report. We normally don't have payment increases as part of our June report.

DR. KEMPER: I wonder if it would be possible to handle it in the text rather than making a recommendation.

DR. WILENSKY: That is what I meant.

DR. KEMPER: So we wouldn't have that.

DR. WILENSKY: Yes.

DR. LEWERS: Let's think about that for a minute because I think we want Congress to understand that this is an important part related to quality. If it's buried in the text, that's not going to get across.

DR. CURRERI: Maybe we ought to say that in the recommendation, that MedPAC thinks that it's an important aspect of improving quality is --

DR. WILENSKY: Okay. I think it's important to make it as an appropriate part of the June report. I have no problem.

MS. RAY: The third and fourth recommendations address the treatment of malnutrition of dialysis patients. HCFA's core indicator data suggests that there has been no clinically important changes in the nutritional status of dialysis patients over the last several years.

Enteral and parenteral nutrition are covered as a DME benefit which restricts the number of patients who can qualify. The first recommendation is recommending coverage for these interventions as a renal benefit.

The second recommendation. There have been already a number of observational studies and case reports and randomized trials supporting the use of these interventions. However, there has been no large randomized controlled trial about evaluating these interventions among malnourished dialysis patients.

Just to add on that several organizations and researchers have already published pretty thorough outlines of study designs for such studies.

DR. LAVE: I would think that you want to do the demonstration before you pay for it. So first of all, if you were going to pay for it, they should be reversed. The second question that I have is a different one and that is, are there other medical conditions for which, in fact, malnourishment is also a concern, or is this predominantly a concern for this population?

DR. ROWE: Cancer, AIDS.

DR. LAVE: That's what I was going to say. I'm not sure why we are concerned with this population only with respect to nutrition. I think it's a bigger issue. This issue, I think, is a much bigger issue than ESRD and we may want to do a demonstration with respect to ESRD, but I have

concerns about the coverage until we address the question of why ESRD and not cancer and AIDS and whatever other conditions that people get malnourished.

MS. RAY: I would just say that nutrition and malnutrition is a critical problem of ESRD patients that has been linked to their outcomes, and that malnutrition has been linked to higher rates of hospitalization as well as premature mortality.

So it is a specific problem, although it is among other patient cohorts, but it is a very specific problem among ESRD patients.

DR. LAVE: I think, Judy, you have to understand that not all nutrition is not the same and the nutritional intervention in these patients would be very specific and very importantly different from patients who have kidney function who might have AIDS or cancer.

I think that it's right. I think that what I think would be better would be the secretary should support research. I don't know why NIH shouldn't support research, first of all. I guess the secretary runs NIH, so this is not HCFA.

DR. WILENSKY: NIH doesn't like to acknowledge it,

but actually the secretary --

DR. ROWE: This is not HCFA. This is the Secretary should support research evaluating the efficacy of nutritional interventions in patients with end-stage renal disease, whether or not they're on dialysis, is really the key here because --

DR. LAVE: They did a number of demonstrations some while ago on the use of nutrition to try to delay the onset of dialysis.

DR. ROWE: Sure, neutrino acids and things like this.

DR. LAVE: I'm wondering why you said end-stage renal disease rather than dialysis because aren't you concerned particularly here for dialysis, because they did do some of the preliminary stuff prior to dialysis earlier. I don't know. I was trying to figure out whether or not you were looking at nutrition as an intervention to delay dialysis.

DR. ROWE: No. I just think that a lot of patients on dialysis, but a lot of patients not yet on dialysis are malnourished.

DR. CURRERI: It would seem to me that this would

be -- I don't know exactly what you mean, the secretary should support research. I read that as provide dollars. But I think that actually --

DR. LAVE: To fund research.

DR. CURRERI: -- I would think the manufacturers would provide the dollars because this is a real source of potential profit.

DR. NEWHOUSE: Why haven't they?

DR. ROWE: Some of these things may not really have intellectual property rights to them because they may not be --

DR. NEWHOUSE: So then we're back to the secretary.

DR. ROWE: They may be just things that you could buy over-the-counter, it's just the mix and the dose.

DR. WILENSKY: The issue, I think, either we need to again flip these concepts where you need to have established the clinical criteria and as part of that, maybe to fund research or a demonstration program to establish the efficacy and then that would lead it, depending on the results, to coverage.

DR. CURRERI: I really believe that there is

strong evidence -- I think Ted would agree with me -- that nutritional support is a very important part of the treatment for people with ESRD, and I disagree with you, Judy, that we should do the evaluation first because that may take three or four years if you're going to do double-blind studies and so forth.

DR. LAVE: I guess I'm sort of concerned about how we can have somebody to do research to support it before -- it just seems a little strange, that's all, that we order them in this way.

MS. RAY: There are studies. Unfortunately, there isn't a really good, large, randomized case control kind of an evaluation that's been done, and I would look to physicians for -- there have been many studies, observational and case report design, that have shown the benefits of these therapies in treating dialysis patients.

DR. ROWE: I think, Judy, you're at risk for having the perfect drive out the good here. I mean, I think we know enough about what to do with these patients. We need to know more, but if we used the criteria that I think you might want to apply about having the huge, randomized, controlled, double-blind trial, that proves that we never

would have given polio vaccine to those kids in the late '50s.

I mean, I think we need to -- there is a lot of information there to suggest what direction we should go in and in addition, there's a need for more information. I think that's what I hear.

MS. RAY: That's exactly what I'm getting after.

DR. LEWERS: And in many people of the people, the patients who are malnourished need more dialysis. And so, you tie the two together. You give more dialysis, they improve, they feel better, they eat better. But if you try to give them the enteral feedings, that's not covered. They cannot get it, they can't afford it, and in my units, we used to rely solely on the companies to provide it for us so we could give it to these people.

When I went to meetings, I would come home with a bagful of the stuff that I'd hand over to my dialysis unit to give out because people couldn't afford it, and that's the point, I think, that Nancy is trying to get to. Generally, this is a short-term factor. You really need to dialyze them more and once they're dialyzed more, they do much better.

DR. CURRERI: But the most serious side effect of malnutrition in these as well as other patients is respiratory infections because the first major muscle mass they lose is their intercostal muscle mass so they have much increased work of breathing and decreased respiratory volume and they get pneumonia and that's true with all malnourished patients. So you put them at high risk for ancillary infections.

DR. WILENSKY: Do you think if we were to reverse the order and have the secretary establish clinical criteria, are we in a position in terms of our state of knowledge that you think that is a reasonable recommendation, that the secretary should establish these clinical criteria and then we establish coverage based on those?

It would strike me that the concerns that are being raised, if we can have clinical criteria established, then presumably we would then be in a position --

DR. ROWE: A definition of malnourishment is available that could be operationalized and measured on the patient.

DR. CURRERI: Absolutely.

DR. WILENSKY: That really strikes me as being -- then responding to the issues that we raised. Are other people comfortable with taking that approach?

DR. NEWHOUSE: I'm comfortable with the recommendation, but just as a matter of procedure, since we're recommending an expansion of benefits, isn't it incumbent on us to give some sense of cost? In what position are we with respect to saying what this might cost?

DR. CURRERI: I guess it really would depend on the identification of the proportion of patients that fit whatever the criteria that the secretary is going to set out because the cost is going to be related to the volume of patients receiving the care.

MS. RAY: That's a tricky question because you would expect there to be a reduction in possibly rates of hospital admission if these interventions were provided. That is --

DR. LAVE: Another offset.

MS. RAY: Yes.

DR. WILENSKY: Why don't we put aside the offsets for the moment. Do we have an estimate of the direct costs?

MS. RAY: No, we don't.

DR. WILENSKY: At the very least, we have to note that we do not have an estimate before it's actually -- we go forward with this. We would need to have a direct estimate as to what the cost would be of providing coverage.

DR. CURRERI: I don't think that would be a hard figure to get, though. I think we could get those numbers pretty easily.

DR. WILENSKY: You might want to see whether you can have that discussion with HCFA. If there have been estimates already as opposed to just indicating that we recognize that this is additional cost to the system, although there may be some offsetting reductions. I'm always a little dubious about capturing those offsetting reductions myself.

MS. RAY: I just have actually one last question. Do we want to add a fifth recommendation regarding the HCFA funding quality efforts in working with the "renal community?" Is that something we want to go ahead with?

DR. LEWERS: I do. I think that would offset a lot of costs if we could just spend a few dollars on that.

DR. WILENSKY: Any objection?

DR. CURRERI: I don't have an objection, but I

thought you said they were doing that already.

DR. LEWERS: There are some studies that are underway. Remember we talked last month about looking at some of the quality parameters and things of that nature that are being done, but I think that HCFA, as expending all the funds expending, need to be involved in some way. I think it would put a lot more emphasis on it and really give it a major impetus. That's my reason for thinking that.

DR. WILENSKY: Could you come back tomorrow and show us the wording of such a recommendation? Let's look at it and make sure that we're comfortable adding this.

DR. ROWE: When we discussed this last month, one of the questions that came up is when we discuss the fact that payments haven't been increased since 1983 or whatever. Was it the observation that there continues to be entry into the market? I think we were going to try to include something in the chapter about whether that was still the case or not. It's part of the discussion about it.

Do we know whether, in fact, there still is entry into the market and new dialysis companies or slots or units or whatever?

MS. RAY: I haven't done a detailed analysis of

that. At least just based on my reading, there are several big players involved in having and acquiring dialysis facilities.

DR. ROWE: Right, but they may be consolidating their ownership existing capacity as opposed to developing new capacity.

DR. CURRERI: We do know that volume of number of patients has gone up dramatically. I think we pointed that out.

DR. ROWE: The other thing is, I think the first sentence of your relevance to policy-makers might be reviewed. You say the dominance of HCFA in financing ESRD care has resulted in claims by the renal community that reimbursement policy has jeopardized quality. I think people in the renal community might say it doesn't matter who's paying. The fact that payment hasn't been increased in a long period of time has jeopardized, not necessarily --

DR. NEWHOUSE: Wait a minute. Do we know that that's true for the private pay side?

DR. ROWE: Well, I only know the share of epos. It's about 20 percent of the epo market. I don't see any reason why it should be true on the private side. But just

the way it's worded, it sounds like because the government is paying, people are complaining it's not enough.

DR. NEWHOUSE: But it's the government rate that's been held constant.

DR. ROWE: Then we should say, the lack of a change in the government rate has resulted in continuing --

DR. NEWHOUSE: Fine, fine.

DR. ROWE: That's the point.

DR. LEWERS: I had a problem with that and that needs to go into the other parts of the chapter. The other area in that same sentence that I had a problem with is by the renal community, claims by the renal community. You use that at least four or five times in the chapter and indeed, there are more than the renal community who are saying that.

You point out on Page 7 about the IOM study of '91 that was mandated, I think, in '87. They said the same thing.

DR. WILENSKY: Where are you referencing? What is driving this?

DR. ROWE: It's the first sentence of relevance to policy-makers.

DR. LEWERS: It's in a couple of places. It's

there; it's on improving quality, the second page; it's on Page 2; it's on Page 5. But the point is, we do quote IOM study and there are more than just the renal community who are saying this and we need to make sure that's part of it. You don't reference the IOM study and I couldn't find it in the references.

MS. RAY: There was a typo. I apologize for that. It's since been fixed. It's actually there. I apologize.

DR. KEMPER: Nancy, I just wonder if you could clarify for me. You have a table on reasons for hospitalization and then you say the findings confirm that inadequate dialysis is the reason for the hospitalizations. How do you conclude that?

MS. RAY: That was actually drawn from the paper, that many of the reasons for hospitalization are suggestive that inadequacy of dialysis contributed to the hospitalization.

DR. KEMPER: Because of the diagnoses?

MS. RAY: Yes.

DR. KEMPER: Maybe you could just clarify that.

DR. CURRERI: One little editorial comment. On Page 14, you have a sentence just before draft

recommendation three that is lacking a word at the end and I think it's available. It says the prevalence of --

MS. RAY: I actually have picked that up. Thank you, though, for pointing that out.

MR. SHEA: Just quickly. We had some discussion last time about the validity of the international data. I thought we were going to do some reference point about needing to resolve that.

MS. RAY: Right. And actually, there is a sentence in the text and perhaps it could be strengthened, but there's a very large, well-designed observational study going on comparing practice patterns in the United States to five European countries and Japan.

I think that will really address a lot of the questions about the whole issue about mortality rates and so forth.

MR. SHEA: I saw one reference in here, but I didn't get that we were saying anything about the importance of doing this. I thought that's what we wanted to do.

MS. RAY: I will strengthen that.

DR. LEWERS: Maybe you could beef up that part.

MS. RAY: Yes, I'll beef that up.

DR. LEWERS: I have one other area to beef up. On Page 7, the paragraph about inadequate dialysis, the 30 percent. I think you ought to talk about the improvement that has occurred recently. I mean, let's put it in there. We have done a good job and it's changed dramatically over the last couple of years and we ignore it completely. We can't do that.

I would be careful, on the same page, longer treatment could facilitate the removal of larger molecules. You're getting in an area that is debated. I'm not so sure I would want to put that in there. I'd stay away from that. I have some other notes that I'll give you.

DR. LAVE: I just had a question about compliance. I would have thought that a 2.3 percent failure to comply was a low rate lack of compliance and you seem to indicate that's a high rate.

MS. RAY: Compared to the other countries it is and it's been noted in the literature about patients' compliance with dialysis and it's problematic.

DR. LAVE: Two percent doesn't sound very problematic. I would have thought 10 percent --

DR. CURRERI: Well, 2 percent is pretty high if

it's a fatal disease.

DR. LEWERS: And also how you define compliance. I think we might get a comment in public comment on that because there was a conference recently. Are you going to comment on that later in the public comment about the compliance program?

MR. GREER: I can do that. I wasn't planning on it, but I'd be happy to.

DR. LAVE: You may want to just say something. It struck me if you were really looking at how bad compliance was, it wouldn't have hit me over the head with that number.

DR. WILENSKY: Why don't we do, because this session is clearly separated from the rest of the afternoon, if there are any public comments? You don't need to respond to the issue of whether 2 percent is high or a low number, but if there are issues that people would like to raise with regard to our report, this would be an appropriate time.

MS. SMITH: Thank you. My name is Kathleen Smith and I'm the vice president of government affairs for Presentius Medical Care North America, which is the largest provider of dialysis services in the United States. We care for approximately one-fourth of the dialysis patients in

this country.

I'd like to speak first to recommendation one and applaud the staff for focusing on the issue of dialysis adequacy in the chapter. However, as Dr. Lewers started out with his comments, there are a number of factors related to adequacy of dialysis and those of dialysis prescribed and delivered.

The frequency of the dialysis and the length of time of each dialysis session are only two of those factors. So to pay based only on those two, I don't think would be wise for the Medicare program or necessarily have the positive impact you're hoping for on the beneficiaries.

If you're moving in the direction of taking a solid look at dialysis adequacy or dose, especially in light of the conversation with regard to quality in the overall Medicare program that we just concluded prior to lunch, the focus should seem to me to be on differential composite rate payments based on a level of outcome that is achieved.

That moves us a little further away from going back to cost-based reimbursement and more prospectively paying in recognition of the outcome that you are seeking. That would also link us a little bit to the discussion on

malnutrition. If malnutrition, for example, is going to be monitored by albumin level, our experience is at least a twofold to threefold increase in the rates of hospitalization for patients whose albumin is 3.0 as opposed to 4.0 grams.

So one of the indicators for outcome could be albumin as well as anemia. These outcomes are well-recognized in the renal community. Dr. Lewers mentioned an awful lot of the work that has been done by science in the community and would appear to me we have URR, we have anemia, we have albumin. These would be factors that we could pull all together to focus and move and drive the providers in the direction of a focus on quality and outcomes.

The only other comment I'd like to make was the more recent comment on the table on Page 17 which lists as the most frequent cause for hospitalization is chronic renal failure. Even if these patients have problems with the adequacy of their dialysis, that in itself doesn't lead to an admission that would be labelled as chronic renal failure.

I think this table speaks to the problems that we

have today with tracking the accurate real diagnoses for admissions and the problem of misdiagnosis that we have. I wouldn't want that to flavor the conclusions of the commissioners because they are rarely truly admitted for their underlying doses of chronic renal failure.

I think Dr. Lewers is nodding on that one. So I thank you for the opportunity to make these comments.

DR. ROWE: Are the chapters distributed before the meeting?

DR. WILENSKY: In this case, we had chapters distributed because we wanted to have some comments from the relevant communities for technical review, and because of the time constraint, this was the only way to do it. Normally they are not. I think there had been at least alerting or maybe not that we were going to do this because we wanted to make sure we had input on technical issues.

MR. STEVEN: Good afternoon, my name is Christopher Steven from Baker & Hostetler and on behalf of Renal Management Strategies from Baxter Health Care, we'd like to thank you for your focus on this critical issue to so many beneficiaries.

A few weeks ago we provided a study to Nancy Ray

in regard to the deficiencies in the AAPCC and also Section 1876. In summary, we would urge MedPAC to endorse our recommendation to lift the statutory bar, Section 1876, on allowing Medicare+Choice enrollees to enroll in -- for ESRD beneficiaries to enroll in managed care.

The Congress in the BBA '97 allowed beneficiaries who are currently enrolled in Medicare+Choice to stay in those plans if they are later diagnosed with ESRD, but those diagnosed with ESRD prior to enrollment are not allowed to enroll.

Removing the 1876 bar will allow more choice in beneficiaries and also better access to care. So again, we would urge MedPAC in its recommendations to examine the Section 1876 statutory bar and also the deficiency of the AAPCC rate. Thank you.

MR. GREER: I'm Joel Greer. I work for HCFA but I am not authorized to speak for the agency, which suits me and them both quite adequately. I only have a query for the committee. I can provide technical comments in a written form and will do so.

The specific query, in the draft recommendation on nutrition, it says as a renal benefit separate from the

composite rate. I think I'm quoting correctly. My query is, why is it important to put in separate from the composite rate? I think that is an issue for discussion. It's an opinion.

DR. WILENSKY: That's actually a very good point, as to whether or not having made the recommendation of having an increase, if we were to at least allow this to be a covered benefit, we could do so without having a separate payment, but to allow for the benefit to be covered. I would support that.

DR. LAVE: Well, we'd just have to put more money into it. I mean, to say that they're going to cover it, they could probably cover it now under that.

DR. WILENSKY: No, they can't actually.

DR. LAVE: They can't?

DR. WILENSKY: They cannot. It's an OIG issue.

DR. LAVE: But wouldn't we want to have money associated with it?

DR. WILENSKY: There's a question of whether we would want to make an adjustment or to say that that might suggest, because we are including this, that we said 2.3 to 2.9, that it might make more sense to go to the top end

or to try to explicitly allow that into the composite factor.

But what I took away, which appeals to me, is the notion that we ought to have a composite rate reflect the ability to cover in cases where needed nutritional supplements and have it as a covered benefit without having it necessarily an independent and separate cost.

DR. LONG: Is it the case that this third or so of the population that exhibits the malnutrition characteristics would be the same proportion of the population that is likely to go into a higher tier of rate in terms of needing more dialysis or greater frequency dialysis or is it distributed evenly across the population?

DR. ROWE: I wouldn't think so. I'm a little concerned, Gail, just thinking about it with respect to this comment of the gentlemen who apparently is at but not for HCFA. From the beneficiaries' point of view, I don't want to create a disincentive for the provider to give the nutritional supplements to the patients because if you fold it into the composite rate, it's a little bit, you know, since they feel under-compensated to begin with, they're not going to feel like they're being paid for this.

DR. NEWHOUSE: You treat it like epo.

DR. CURRERI: And there is a precedent. That's what I was going to say.

DR. ROWE: So I'm a little concerned about that given where we are in the history of this.

DR. WILENSKY: Let me suggest a compromise. I think at the least, we should recommend that it be allowed to be paid for from the composite rate, although we can recommend a separate rate. The reason I'm saying that is that it strikes me that there is a greater likelihood that we could at least allow this to be included as a covered service within the existing rate than it is that we will see Congress also provide allowance.

DR. ROWE: I see.

DR. WILENSKY: I don't really object to having the separable coverage if people can work out how to do that, although when we do DRGs, when we want to have a DRG payment modified to include something, we think about whether the payment is adequate and if it's not, we up the payment and allow for that to be included.

But at the very least, we could say within the composite rate, it could be included.

DR. ROWE: A composite rate should be increased in order to compensate for the provision of this. How would that be, rather than within the composite rate?

DR. CURRERI: Would you fold erythropoietin into that?

DR. WILENSKY: Since that has been -- I would just leave it as it is because that's how we've done it.

MR. MacBAIN: The argument that we can get out of the composite rate are pretty much the same as for mixed or partial capitation where you've got other things that you want to happen. I would rather see us make one recommendation that nutrition supplements be included as a covered benefit, and then a second recommendation that there be specific provisions to pay for them outside the composite rate and not raise the issue of covering in the composite rate because that's a little too easy to say, okay, we'll still pay what we've paid since 1982, but now you also get the covered nutrition.

DR. NEWHOUSE: Is that what we call an unfunded mandate?

MR. MacBAIN: I'm just a little nervous about leaving that. It's too easy a chute to go down.

DR. WILENSKY: The concern I have is that I don't think we have a better outcome if we don't see the increase and we still make it a violation of current procedures.

MR. MacBAIN: It definitely ought to be a covered benefit.

DR. WILENSKY: So as long as we can do -- I have no problem with that.

MR. MacBAIN: Once you allow it, you mandate it and then raise the issue --

DR. WILENSKY: I don't have any problem. I don't think that we're better off to have it not allowed for coverage, which is what we are now.

DR. KEMPER: How easy is it to develop criteria for when the benefit would be paid if it's a separate benefit?

DR. CURRERI: I don't think it would be all that difficult. It might change over time and that's why that should be a regulation, just as the hematocrit changed over time. But I think you could easily establish a starting point.

MR. AHAB: I'll be brief. My name is David Ahab. I represent a small, start-up dialysis manufacturer by the

name of Access. I'd like to quickly address the issue of entrance into the marketplace. I think you can look at your previous MedPAC report plus probably the next four or five ProPAC reports on any new technologies that have been introduced in the marketplace and you will see that there have been very little if any.

The second point is, I think you should not only look at mergers of companies, but also valuations. The last two rather sizable mergers of entities, their valuations dropped out, the bottom fell out and they're about the half the value they were when they were first merged.

So I think any analyst will give you a very honest answer to that question to be included in your report because I think that's important in light of many of the comments.

And lastly, I'd like to thank you very much for your work in this area. You've done a superb job of looking at some very difficult issues and I especially thank you for addressing the more frequency of dialysis time. Thank you.

DR. WILENSKY: Thank you, Nancy. I do think that having in the last couple of years said we were going to spend more time and attention on this issue, actually this

time we've done it. I agree.

DR. NEWHOUSE: Even without being paid for it.

DR. LAVE: We took it as part of the bundled payment.

DR. WILENSKY: Beth?

MS. DOCTEUR: The draft chapter on addressing health care errors under Medicare is behind Tab D in your mailing materials. Let me begin by apologizing. I had a separate page summarizing the recommendations with a pull-out paragraph, but due to an error on my part, it somehow didn't make it in. I do apologize. You need to flip through the chapter to find the recommendations instead of having them nicely up front.

As you recall, you had a very full discussion of an earlier version of this chapter at the March meeting. As a result, I scrapped three of the four previous recommendations and tried to come up with some new recommendations that represented what I could find to be the sort of greatest common denominator in terms of your discussions and your thinking on this.

I'm not sure that I did, but I still have the black suit and I put some body armor on during lunch, so I

feel prepared to hear your comments.

I thought the best way to do this would be to go through the new recommendations one by one. Beginning with the first recommendation, this is the sole survivor of the last version. Basically it's just saying that Medicare should make patient safety a qualify improvement priority. This was sort of taken as a given.

MR. JOHNSON: Is there any reason that this recommendation is different than the Page 11 recommendation that's in our text that we read before the meeting?

MS. DOCTEUR: This recommendation meaning what's on the overhead? It's just summarized so that we could have fewer overheads.

MR. JOHNSON: The only question I had is in terms of just reading this chapter. In my family, as far as medical care goes, the tolerance for error is zero, but I know that's a higher industry standard than I would want in my other job. I have to live with that.

But seriously, the idea of reducing and targeting and we're going to start playing with words in this chapter, aren't we out to sort of, at all costs as far as humanly possible, minimize medical errors? I know that might mean

reducing them in some cases, but the idea is to make a medical error sort of a de minimis event. It shouldn't happen.

I was just looking at the word reduce in recommendation number one and just offering the word minimize. That's all. It's not a big deal, but it's sort of the philosophy of the whole thing.

MS. DOCTEUR: The second recommendation is on the same page and that's that Medicare should support any utilized ongoing public and private error reduction initiatives. This is basically a replacement of the former recommendation that said the secretary ought to look into the possibility of developing some type of an error reporting system in Medicare and there was some discussion, again, the public/private partnership discussion that you held last time. This is draft recommendation two.

DR. LEWERS: Where we're talking errors here, can we slip in avoidable like we did in one of the other chapters?

MS. DOCTEUR: Yes.

DR. WILENSKY: You used that before and I guess there's some sort of -- I'm not exactly sure what avoidable

error is.

MR. MacBAIN: In industrial quality control, there are two types of error. A special variation which is caused by somebody making a mistake, or something unusual happens that's different from the normal production process, and that's what we're used to thinking of in a punitive regulatory and legal environment that surrounds medicine.

I think that's Ted's sensitivity to saying avoidable errors as opposed to errors that simply happen that you don't want to hang somebody for because any production process has a certain degree of error built into it. But that also needs to be reduced.

Just random errors of a production process, for instance, a laboratory test that has a certain false positive rate will produce a certain number of false positives. Those still are errors and if you can improve the test in order to reduce the number of false positives, you've reduced errors and improved quality.

So while I think it's worthwhile making the distinction between special variation and random variation, to improve quality, you want to focus on both of those.

DR. WILENSKY: That's why I'm a little concerned about the avoidable in the sense that --

DR. CURRERI: It doesn't take care of system.

DR. WILENSKY: Exactly. It doesn't take care of system errors and we don't mean this in a punitive liability sense, but rather, to try to take from other industries where they focus on processes to make it very hard for errors to occur.

DR. ROWE: I think the problem -- what we want to do, while we're not thinking about it in a punitive way, other people may be and some of even the proposed HCFA's proposals about requiring as a condition of participation having error rates at certain levels, if we wind up migrating towards that position, we want to take out of that number these unavoidable errors so that places are not kicked out of the Medicare program for reasons that are unrelated to the quality of the care they provide.

DR. CURRERI: Could we get around all this by just including individual and systemic errors? I mean, that's what we're really talking about, isn't it?

MR. SHEA: Except they're not quite a clean separation. People make mistakes if the environment is

conducive to mistakes. You can engineer out the --

DR. WILENSKY: I'm a little concerned with this focus of including avoidable because the concept -- it may not be the person's fault, but that doesn't mean it wasn't "an avoidable error," if you have reengineered the processes to make it very unlikely or less likely that this would occur.

So I don't have any problem, and I think we, in fact, in the chapters address some of the HCFA proposals, but I don't want to make it sound like well, there's some set of errors that were not considered as being relevant.

DR. ROWE: I think in medical care as opposed to industrial standards, we tend to use the word systems differently. In fact, we view errors in health care as being rarely individual or personal. A small percent of the errors are willful attempts by evil people to do something bad and most of them are system errors.

What we mean by system errors, we didn't have a computer system to check that when you give this drug to somebody that's also on that drug, these two drugs interact or the dose of drug B should be reduced in somebody who has this diagnosis or drug A which reduces the dose. Those are

what we call in health care system errors.

MR. MacBAIN: That's true in manufacturing as well. Even a process that has no human intervention --

DR. ROWE: And I think hospitals should eliminate both those, so I don't think pointing to one versus the other is going to help. I don't think personal versus systematic. Maybe what we can say is use a term like minimal error rates or something like that rather than --

DR. WILENSKY: The avoidable makes me uneasy because I'm not exactly sure what that --

DR. ROWE: Minimal achievable or some realistic --

DR. LAVE: As I read this chapter, it seemed to me that this was trying to frame things into a quality improvement kind of a construct, which is, in fact, that you try to minimize what's going on, you try to assist them there and you try to bring things down.

So I think that minimize is the reasonable one given the framework that we have. Just say we identified the problem and our goal is to continue to shrink them.

DR. WILENSKY: I agree. I thought that having quality improvement priorities and minimizing error really does reflect that.

DR. NEWHOUSE: I had a different reaction that actually applies to both minimize and to avoidable, which is that I can't come up with a good medical example, but if you think about putting guardrails on highways, there's a class of error that you may not be able to reduce to zero, but if the error happens, you could reduce the consequences of the error.

That didn't really get here, that we might be after that kind of improvement as well.

MR. MacBAIN: What it still comes down to is reducing variation and identifying --

DR. NEWHOUSE: But there may be some -- or if it happens, it has less bad consequences.

MR. MacBAIN: Which reduces the variation of outcome. You can have something that's going to be very bad, like the car going over the cliff when it hits the guardrail, and so it's not --

DR. NEWHOUSE: Yes.

DR. ROWE: I think the other consideration that should be in the narrative with respect to this definition is that not everything that goes wrong in medicine is an error. I mean, good doctors have bad outcomes sometimes.

If you do 100 or 1,000 or 10,000 heart operations, some proportion of the problem is going to have a problem.

DR. NEWHOUSE: That's the false positive example.

DR. ROWE: And I think we should distinguish that from a mistake, which is what error sounds like.

MR. MacBAIN: But it's still important if there are ways to reduce that natural variation.

DR. NEWHOUSE: Or reduce the consequences of it.

DR. ROWE: I agree, but I think that's really the point, is that not every bad outcome is malpractice or a mistake.

MR. MacBAIN: It's simply the nature of a process that is subject to improvement. It's too bad Woody isn't here because he could talk about Ford Motor Company when they talk about Six Sigma quality, they're talking about reducing random variation. They're not talking about --

MR. JOHNSON: But don't we want health care to be better than my Explorer's transmission?

[Laughter.]

MR. MacBAIN: You've got the one in a million.

MR. JOHNSON: Evidently.

DR. LEWERS: I think we're all talking the same

thing. We want to make this very clear. The avoidable error, I've been reading this in a lot of material people have been writing about this in the quality area and preventing of errors.

I think that we can get some help for the proper language from these individuals who work in it every day more than we do. I'm not an expert in this either. We get rid of systems and many of the errors are avoidable because the system is not right.

So I think there has to be some appropriate wording that doesn't lead us into the area that Jack's talking about to the wrong implication. So I'd just recommend that instead of us writing it, let's try to get that clarification.

MS. DOCTEUR: I think a few places throughout the paper I tried to use the term preventable error to distinguish from other types of error that aren't preventable and I could do that more consistently and put it in the title and make it clear that that's what we're talking about, not adverse events as a whole.

DR. LEWERS: My point is we don't want to be outside of the realm of what's being written elsewhere with

terminology which is not appropriate.

MS. DOCTEUR: That's the term I've read and avoidable errors, I think, is another good term, too.

MR. MacBAIN: It concerns me that there is -- it implies there's this whole class of errors that aren't preventable or aren't avoidable and so we're going to live with them. That's not necessarily true. There are a whole -- there's a whole class of things that cause variation in outcomes and the more we can do to improve the systems, the more we can do to reduce that variation.

DR. LAVE: I think the question is, is there a different -- I mean, what we are trying to do here, I think, is split a hair and that is, there are two issues, one of which is quality improvement generically, which is what we talked about before. The other one is quality improvement which is associated with errors.

So, for instance, improving the generic quality of open-heart surgery is sort of in one case, and the error issue might be a separate one and I don't think that we want the error discussion to encompass all quality improvements, which is what I think this conversation is leading us to do.

So I think that because we've separated this out,

we must have something different in mind when we talk about an error, which is different from a bad outcome because our skills aren't terrific or whatever it is.

So I think an error has to mean something. Otherwise, we'd just be talking about quality improvement when we're focusing on errors.

MR. JOHNSON: On the other hand, I was going to say, one of my comments overall in this chapter is I thought this was a subpart of the quality chapter almost for an absent reason and I would ask Bill this, that if you had really good practice protocols or standards or systems in this case, wouldn't that reduce your errors on the other end?

MR. MacBAIN: Yes, that sort of thing, electronic feedback systems that ask you if there are two drugs that have very similar names, is this really the one you wanted to prescribe, or they give you a sense that no, this dosage doesn't fit the age of the patient. Any of that kind of thing that identifies the human error that puts the wrong number on a prescription pad is --

DR. ROWE: Or you have three patients in the same ward with the same name.

MR. MacBAIN: That's a random event, that that happens. Once it happens, you've got a high probability of human error that you might identify as boy, that person really messed up when in reality, you've got a random situation that there are other ways to handle that that greatly reduce the likelihood of people who are well-trained who almost never make an error making an error.

DR. KEMPER: I think Ted has a really good point. I think preventable errors, there's a better term. It really ought to go in there, but I think the text ought to have a discussion that there are a lot of dimensions of that and it includes reducing random error where that's possible, reducing system error, reducing individual error, all the components of it so that at least it would be clear.

But to me, the preventable recognizes that there are going to be some errors left after you've done everything that you can do.

DR. WILENSKY: Let me go back and just offer a suggestion with regard to whether this is two chapters or one. I would see that at the least, they would be companion chapters and that they ought to be proximate in terms of their location. I'll leave it to you as to whether for size

and consistency with the rest of the volume you'd like to have them as separate chapters, but following each other, and cross-referenced or not.

MS. DOCTEUR: I saw these as very much related chapters, also, and certainly the conceptual thinking about quality problems relates to over-use, under-use, and misuse of which errors is synonymous.

DR. LAVE: Can we move in medication errors up after errors, because they're a subset of errors rather than a subset of autopsy?

MS. DOCTEUR: I think the reason, in my mind, these were distinct chapters was several reasons, but one of the most important was that this was -- to use Jack Rowe's terminology, this was more a content chapter or substance chapter, really getting into trying to focus on what the quality problem was as opposed to just focusing on systems for trying to address problems.

DR. ROWE: I wonder whether we need in the document, in the June report, a one to two-page --

DR. LAVE: Venn diagram?

[Laughter.]

DR. ROWE: Actually the term that came to mind was

prolegomenon.

[Laughter.]

DR. ROSS: For those of us who went to the same schools.

MR. MacBAIN: It's a clump of words added to the front of something.

DR. ROWE: I think I should get credit for coming here.

MR. MacBAIN: You do.

DR. ROWE: I hadn't noticed. A one to two-page overview abridging document about the various aspects of quality and the content aspect and the regulatory aspect is all we need. Then we can put these chapters in any order or separate or the same.

MR. SHEA: I think they are very much related. I think there's a good argument for keeping them separate, though, which is that we're talking here about baseline patient safety. We're not talking about the ever and ever better, higher quality reach, which is what is usually referred to in terms of the quality and where the focus has been and this is now a focus of a lot of activity.

I think it would be important to have it

highlighted a little bit as a context section in something that we're recommending be a priority within the overall.

MR. JOHNSON: I think there's a certain contradiction or tension here because on one hand, we're trying to use the experience in the other sectors to jump-start the health care sector, which we might think is more art than science, and try to do this sort of process and system stuff.

It's sort of like using hand grenades to make rifle shots. I'm not sure we can describe all the systems that are going to work or not going to work here. There's going to have to be some experimentation. So I guess what I would like to see is the idea of like there's more text of certainty in this draft chapter than I think there is certainty, although I think the recommendations are the right recommendations.

I guess it's like you said before earlier about the errors chapter, that there was more problem with the text than the recommendations. I think it's this tension of trying to find exactly the right thing and not waste the time and just transplant it from another industry.

I guess all I can think of is putting a nuclear

reactor in every hospital or putting all operating rooms on airplanes to reduce, but I won't go there.

DR. CURRERI: I think there has been a fair amount of experimentation, we just didn't call it that. For instance, in nosocomial infections in hospitals, hand-washing procedures and monitoring of that, those are all examples of system failures really. They're not necessarily individual failures and the reduction in nosocomial infections has responded to that kind of experimentation.

MR. JOHNSON: But don't you think with these targets and standards and all these other things, we're trying to push it to a real process quantifiable outcome measurable to the tenth decimal point experience?

DR. CURRERI: I would agree with the tenth decimal point, but...

MR. MacBAIN: The logic is the same and that's identifying ways to reduce random variation, but the processes are very different and the product you're working with is a human being, which is a whole lot different from steel.

MR. JOHNSON: At least two human beings.

MS. DOCTEUR: The third recommendation is similar

to one that you discussed at the last meeting. It basically calls for Medicare to consider opportunities for addressing error in developing coverage in payment policies, quality measurement initiatives, and quality improvement programs.

What's missing from this list that was there last time was the conditions of participation that was the subject of extensive discussion last time. So that's the change to this.

MR. JOHNSON: I think there's certain irony that conditions of participation spells COPS in your acronyms in your chapter.

MR. SHEA: This is more related to two than to three, but it could go either way. There's a little bit of sense that I got from the writing here of Medicare being sort of behind the curve here. I don't know whether we need to make a judgment at all.

I do think, though, that it would be useful to have a positive statement about Medicare needs to play a leadership role in this area.

MS. DOCTEUR: The fourth recommendation again is a new recommendation in that it calls for Medicare to work with its providers to define and promote effective and

efficient error reduction processes, structures, and activities, and I think we could pull in some more of the experimental language here.

Another new part of this recommendation is to set progressive targets for improvement in patient safety.

DR. CURRERI: I don't know if I asked you this question last time, and if I did, I don't remember if you answered it. What I'd like to know, and it particularly relates to your discussion at the top of Page 10, is some material, if a QIO was collecting this material, is that protected from discovery?

MS. DOCTEUR: Let me clarify that. The QIOs do have protection in terms of they do not have to disclose the information to a plaintiff's attorney. They've been legislatively protected from that.

The concern, as I understand it, arises in that the state laws are different. So in some cases in certain states, by providing information to the peer review organizations or the quality improvement organizations in that state, that provider might then be subject to the laws of that state and because they've disclosed it, if it's considered external disclosure in that case in that state,

then once they've disclosed it externally, they have to disclose it elsewhere.

Information is protected within the provider and its quality assurance programs internally. PRO has protection. The question is at the state level once they have made the transfer to the PRO.

DR. CURRERI: I just think, to be very honest and very blunt about this with a concern about punitive damages, I simply don't think this kind of a system under the QIO will ever work with the average practitioner who is frightened to death that he's going to lose all his financial security.

So it's got to be protected and we don't really discuss that again.

MS. DOCTEUR: Would you like to make a stronger statement in here? I mean, we refer to the fact that the Joint Commission is actively pursuing getting some federal standards about confidentiality. I mean, would you like to say something more about that other than to note that it's being --

DR. CURRERI: The reason I would like it is because I don't think this nice system that you describe at

the top of Page 10 will ever work unless you have that factor in there. Maybe others disagree.

DR. NEWHOUSE: Does anybody disagree? Maybe you could bring back a recommendation for us tomorrow to look at language.

MR. MacBAIN: I just wanted to add that there are other organizations that collect similar data, particularly managed care companies. Janet, I don't know what your experience is, but that was a concern of ours in Pennsylvania, that we were collecting data that was similar to data that hospitals and QIOs collected, but without the same protections from discovery.

MS. NEWPORT: I would agree and then there's others, like for example, the Department of Labor is requesting information on prior claims experience collection. Hunting through our systems retroactively is really impossible, but it speaks then to the privacy of those 50 other patients and linking up what you can disclose and use under discovery when -- there's conflicting issues in terms of privacy in your systems controls and everything else.

So I think this is a real area that we have to be

very careful about, what kind of direction we go in.

DR. NEWHOUSE: Any other discussion on this recommendation? Okay, onward.

MS. DOCTEUR: This is a new recommendation, also. It specifies that you believe that Medicare should not establish maximum tolerance rates for errors in conditions of participation.

DR. ROWE: I think this is a great recommendation.

MS. DOCTEUR: I should clarify something that's actually inaccurate in the current chapter text. At this point, an external reviewer pointed out to me that HCFA standards for nursing homes do, in fact, at this point specify maximum tolerance rates for errors. I had been aware of that previously, but I thought it was just a Medicaid rule, but it's, of course, both Medicare and Medicaid.

So basically by making this recommendation, you would say not only should they not go ahead and do this for hospitals, presumably, but they should rescind this rule for their nursing homes.

DR. ROWE: I think one of the important things here is that this would -- the only way we're going to get

rid of or minimize errors in medicine is if we know they occur. This would be a dramatic disincentive for institutions to report the presence of errors.

DR. NEWHOUSE: Because it raises the question of what kind of reporting they're getting from nursing homes and whether anybody's been disqualified on the basis of errors.

DR. ROWE: The people who report errors are nurses because they're at the bedside or they're the ones giving the medicine or noticing the effects of whatever, and this would be just a dramatic disincentive. The conditions of participation is such a dramatic nuclear warhead threat that comes out of nowhere.

I'll give you a recent example and that is, some of you may have seen an editorial I published that was critical of HCFA in the New England Journal of Medicine. Forty-eight hours later, we had a spontaneous, unannounced communication indicating that they were going to remove our condition of participation in the Medicare program and we had a one-week on-site review out of nowhere for some previously filed concerns.

I mean, one feels in the environment out there as

if it's a tough regulatory environment and to add more conditions of participation, particularly that are disincentives to report errors is a really scary thing. So I'm not sure, by the way, there's any relationship between those two events that I referred to.

MR. SHEA: It sounds like it could have been preventable, too.

[Laughter.]

DR. ROWE: More than one of my colleagues said, did you have to write that editorial?

MS. NEWPORT: All of this comes together for me in terms of some things that we've been doing in not only my company, but the industry in terms of overarching compliance programs. We've all talked about that, but it has to do with, does an entity, however you want to define that, have processes in place that are structured to improve quality of care going forward.

This is not -- you can't necessarily put this to numbers. There's a lot of work being done there, a lot of benefit to entities, if you excuse the expression, that do this to mitigation. There's a whole body of effort underway which would have helped Jack right away if it had been

there, but I think that we need to look at what is the intent of the process to make sure that errors are kept to the absolute minimum.

I think that somehow I don't feel we've made that clear a statement, that there's a real benefit to having a formal program like that in place. Lots of folks are doing that and hospitals and managed care plans and others and I think that that does speak to not going to sort of arbitrary numerical values, but the process and what you do to manage your risk and what you do to make sure that the outcomes are the optimum.

MR. SHEA: As much as I normally like to associate myself with the opinions of Dr. Rowe, I don't think anybody -- I haven't heard people argue for this, that is setting tolerance rates for errors, but I can imagine if we were at a different state of knowledge or science on this, which we're nowhere near, that someone might say, well, what about target rates in certain limited kind of areas.

So I wonder if taking a position on this now isn't just going up a tree to get ourselves in trouble.

DR. ROWE: I thought HCFA said they were going to do this.

MS. DOCTEUR: HCFA does do this right now for nursing homes and they're planning to do it for hospitals if and when --

DR. ROWE: Oh, they're planning to do it?

MS. DOCTEUR: Yes. They're in the draft conditions of participation for hospitals right now.

DR. ROWE: I agree with Gerry, but I think in this case, they actually are planning on doing it.

MS. DOCTEUR: It's in the draft conditions.

DR. NEWHOUSE: Can I ask about the experience with nursing homes? Has any nursing home been disqualified because of too high an error rate?

MS. DOCTEUR: I can verify that no, but my understanding is no. There's been a whole issue about how well HCFA is enforcing the standards anyway.

DR. NEWHOUSE: So that is certainly consistent with just chilling reporting.

DR. LAVE: Why don't we have a more forceful statement that says something like, we think this is an extraordinarily important issue, that we have to get it started or whatever it is, that we think the FAA thing was very good, and that we think it's premature to in fact make

it part of the conditions of participation if you want to develop good systems.

That strikes me as what we have said all along, what the FAA has said, and what the providers have said.

DR. NEWHOUSE: Remember it didn't work until it got to NASA, so you have to have -- the reporting actually has to be to some body presumably other than HCFA.

DR. LAVE: Right, but it strikes me as being very strange that we have a whole report. The front part of the report says, if you want this to work, you have to remove it from a punitive system, and then for the system to have a recommendation that says, well, we said all that, but we really don't believe it.

DR. ROWE: This says we believe it.

DR. LAVE: Oh, should not, right? Oh, I'm sorry. So I agree with this.

[Laughter.]

DR. ROWE: Could we remove the last 25 minutes from the record?

DR. LAVE: Gerry got me all confused. I thought it was --

DR. NEWHOUSE: Any other discussion of this

recommendation?

MR. SHEA: Can I pursue this just a little bit further?

DR. NEWHOUSE: Sure.

MR. SHEA: Can you give us a little bit of what HCFA's thinking is here? I'm kind of surprised.

MS. DOCTEUR: No.

[Laughter.]

MS. DOCTEUR: Perhaps there's someone here who can enlighten us in public comment, but I can speak to the fact that there has been an extensive outcry from practically any part of the health community that has addressed this particular issue. Anyone who's addressed it completely opposes the idea of setting these standards for reasons that -- some of them are discussed in the chapter text, concerns about the punitive nature of doing this, concerns that it sends a message to beneficiaries that a 5 percent error rate is acceptable when they feel that the message should be that we should always be striving for continuous quality improvement in setting goals for improvement and that zero percent should be our ultimate goal. So are sort of the concerns. I haven't seen a response from HCFA,

unfortunately.

MR. SHEA: And if people knew what the error rate really was, they'd really be upset. I guess I'm just a little bit uncomfortable, but I think I'm probably in a minority position.

DR. ROWE: The other thing is, it's something that -- not only is it a disincentive for reporting, but it's an incentive for gaming because this is a rate and that means there's a numerator and denominator. You want to get your rate down? Okay. Everybody who gets admitted to the hospital gets the following four medicines, you know, aspirin, Maalox, whatever, boom, boom, boom, and all of that goes into the denominator.

So whatever your error rate is, you're reducing it because you're making sure that there are 10,000 a week errors that are right because you make them really simple. So the rate goes down. I mean, it's just stupid. Why don't we have a recommendation saying, we think that this idea is stupid?

[Laughter.]

MR. MacBAIN: I think we should a footnote with Jack's quote and a picture.

MS. NEWPORT: You could get another letter here, Jack.

DR. WILENSKY: Have we been sufficiently helpful?

DR. NEWHOUSE: We've got one more recommendation. Now we come to the post-mortem.

MS. DOCTEUR: We have changed the recommendation on autopsies. The last recommendation, as you'll recall, called for the secretary to take active steps to encourage, I think, appropriate use of autopsies and there was an extensive conversation about our inability to determine what the appropriate rate is at this point.

This recommendation then is changed to now say that the secretary should fund research to study appropriate use of autopsies to try to determine either appropriate rates or to understand better the costs and benefits and to try to quantify those so we can understand how much we should be doing here.

The second part of the recommendation is to then do work to assess the benefits of using information in autopsies, from autopsies in efforts to improve quality and reduce errors.

DR. WILENSKY: Beth, in the text surrounding this

part, I think twice you make a statement or reference the sentiment that George Lundberg had made that the autopsy costs from the hospital level are included in the DRG base. I thought after he had presented, someone had commented that that is actually not the case; that when DRGs were put together, those costs were not included in the base because they are not a benefit to Medicare.

MS. DOCTEUR: I spoke with that person who did make that comment and we've clarified that she was in fact in error. It's true that it's not a covered benefit and it never was, but it's never been paid for as a covered benefit. It's been part of acceptable costs for quality and administrative overhead.

So it's in there, it's in the cost center, but it was never a covered benefit so it was never covered explicitly. That's why it's so hard to determine what the cost of this thing is because it's not a specific line item. It's buried in others.

DR. ROWE: It's in the cost report?

MS. DOCTEUR: Right.

DR. ROWE: In pathology or something like that?

MS. DOCTEUR: Yes.

DR. WILENSKY: So presumably it is in Part A, but it would not be in Part B?

MS. DOCTEUR: That's exactly right.

DR. LEWERS: Hospital costs.

MS. DOCTEUR: Yes, hospital costs, and then the pathologists are reimbursed in different ways through the hospital under the arrangements that they make.

DR. CURRERI: I don't know if this is inherent in the recommendation or not because it's a fairly general recommendation, but to me, I think one of the -- maybe this should be stated specifically if the others agree with me, but I think that the research that the secretary does should not only study the appropriate use, but also establish targeted disease states or targeted mortalities that pose a potential problem.

In other words, to me it makes no sense to increase the autopsy rate to look at people that were dying of terminal cancer and everybody do it. You really want to target, it seems to me, those that are most likely to produce errors in diagnosis or errors in technique or whatever.

I don't know how to say that and whether that

ought to be specific, but I think to establish some sort of target population is very important to get the maximum utilization out of minimum number of autopsies and that's cost-effective as well.

DR. NEWHOUSE: I may be in a minority here given last time, and I don't disagree with these recommendations, but I am prepared to believe that the autopsy rate is too low without knowing what the right rate is and that it won't go up without payment.

You've got some discussion of payment in here, but as I read the case you made, I mean, you tried to be balanced, but the case against it really seemed like a straw man. I mean, you said this would not be for patient benefit, which is true, but if we decide we want to pay for it, so what.

Then you said it would be after the date of death. Well, it seems like you could write a line of Poe that would say, okay, for autopsy, you pay for after the date of death or nothing else. So that hardly seemed like a very substantive reason.

DR. WILENSKY: And not before the death.

DR. NEWHOUSE: And not before, right. The image I

got was the computer was set to reject any claim that appeared after the date of death, but you could clearly program the computer otherwise for an autopsy code.

Then I guess the other reaction I had was you gave a figure of $245 million for doing this.

MS. DOCTEUR: Let me say something about that because I did get some useful comments from some of the pathologist groups and they asked that we remove those cost data from the chapter and perhaps call for some real research on what the costs are, because I noted how poor the data are in the text and tried to give an example of the variability in the range, but I wouldn't take that number for very much.

DR. NEWHOUSE: All right. Then I don't think we should go further than where you go, although as I say, I might take out the arguments in the text you make against it. I was just going to note that the number was about -- as I calculate it, was about three-tenths of a percent of total hospital reimbursement, which kind of seemed like close to our rounding error in our update recommendations each year.

MR. JOHNSON: I was going back more to Bill's

comment. On Page 21 at the bottom, it talks about under Medicare's current requirements, hospital medical staff must attempt to secure autopsies in cases of unusual deaths or deaths of medical, legal, or educational interest.

It seems to me that all the criteria are right there. The issue is, I guess, just whether or not doing more autopsies would somehow help the quality process or systems or errors issue.

At the same time, though, we note just above that that the Joint Commission in its wisdom and omnipotence dropped its requirements for autopsy apparently in favor of requirements for seminal events which they felt were more useful in terms of addressing the quality issue.

So again, it goes back to my earlier comment about the text and the chapter. There's a few places that are sort of contradictory in what we're saying.

DR. WILENSKY: Any further comments? Thank you. We're going to skip over the informed consumer choice section for the time being and go to the section on improving care at the end of life, and then payment for graduate medical education. Then we'll see whether or not we take up the informed consumer choice at the end of today

or tomorrow morning.

MR. SHAPIRO: Maybe we should just go through the recommendations in order as well here. These have been reorganized and rewritten from the last time you saw this chapter in March, but I don't think they've changed much in substantive content. The first one is basically the same as in March except we took out the qualifications within a few years and made it now.

The second recommendation is about supporting research and working with professional organizations in the public. That was responding to some suggestions by Ted and others. The second part of this recommendation is really the same as from the March thing, too.

DR. ROWE: It says private organizations, not public organizations.

MR. SHAPIRO: Private organizations, right.

DR. ROWE: As opposed to?

MR. SHAPIRO: Mostly I'm thinking about professional organizations, accrediting organizations, professional societies.

DR. ROWE: Maybe we should say that. It sounds like it's for-profit or something. Non-governmental? Is

that what you mean?

MR. SHAPIRO: Yes, non-public.

DR. WILENSKY: That's fine.

MR. SHAPIRO: Private sector maybe.

DR. WILENSKY: I don't know that --

DR. ROWE: That's even worse, though.

DR. WILENSKY: I was going to say, I think it's somewhat of a bias about what private and private sector means. Basically it means non-public, but there's no problem if you'd like -- at least I don't have a problem if you want to say non-governmental or non-public.

MR. SHAPIRO: How about non-governmental? That's fine with me. Same meaning.

DR. CURRERI: David, can I ask you about one question in your summary paragraph? I'm a little uneasy about the sentence that says the Medicare Payment Advisory Commission joins many others in finding the present situation intolerable. I'm not sure it really is intolerable. I mean, obviously we've limped along with it for a while and we've tolerated it.

I think another word is called for there because that's right in the front of the thing.

MR. SHAPIRO: This is a matter of emphasis that I think I should defer to you on as to how extreme you want to call this problem. Is unacceptable too extreme or is there another word we can come up with? I think there may be some differences of opinion among commissioners on this.

DR. KEMPER: I had the same reaction Bill had, that both the intolerable and some place where you call it the highest priority, I think it's very important, don't misunderstand me. It's just the sort of sky of falling language that I felt went too far.

DR. CURRERI: It's the summary paragraph and the very first paragraph of the chapter.

DR. ROWE: I thought it was mild.

[Laughter.]

DR. WILENSKY: I agree.

MR. SHAPIRO: I'm happy to modify it.

DR. CURRERI: I think unacceptable would be better for me than intolerable.

DR. WILENSKY: I think having a somewhat more moderate tone would be appropriate. This is important, but many of the things we've been talking about like patient safety, for example, could be regarded as equally important.

DR. ROWE: It was worth a try.

MR. SHAPIRO: I'll look through the rest of the text, too, to find any possibly offending words there.

DR. WILENSKY: Immoderate.

MR. SHAPIRO: Or extreme. The third recommendation --

DR. LEWERS: Before you go on, on the second recommendation, I want to make sure, David, we're on the same wavelength with the first. Education, professional. One of the things that I've been reading is that -- one of the problems is that end of life care is not taught in medical school as the professors in medical schools aren't trained basically to teach end of life care.

Are you including that? I didn't see that in the text anywhere. Should we include something about basically part of the curriculum? I hate to get into curriculum because automatically that waves another red flag, but somewhere, I think, we've got to comment that we've got to start early on in teaching end of life care and not leave it until someone's been out in practice for a while.

MR. SHAPIRO: The only mention of it is at the top of Page 3. There's a paragraph about professional

education, which is added since the last version, and there's one sentence about the boards of internal medicine, other boards, and resident review committees that are beginning to require training.

But I don't specifically address it in there and we can add some sentences about educating the educators as well.

DR. LEWERS: I think we ought to add it, if you don't mind.

DR. ROWE: I think the point is that's residency, but it's not medical school. The American Board of Internal Medicine is your residency in internal medicine. You're already out of medical school by then. You're past your formative years, if you will, in terms of curriculum in medical education.

MR. SHAPIRO: I think maybe after the first sentence in this paragraph at the bottom of Page 2 I can say, this training should begin in medical school and go through the different stages.

DR. LEWERS: If we can teach them prenatal care, we ought to be able to teach them how to handle the end of life.

DR. LAVE: The courtship of end of life.

DR. ROWE: We haven't required it.

DR. CURRERI: It's hard to get volunteer patients.

MR. SHAPIRO: This is the third recommendation, I think, which is really the same, unchanged from last time.

DR. LEWERS: I have one comment, not so much on the recommendation, but in the paragraph above it. We talk about quality measures for end of life care are sufficient for use in quality programs. Are they? Then you go on in the next sentence and tell how they're not sufficient. I think we ought to take the word sufficient out.

DR. ROWE: I think you should say that they exist, like Meperidine use in others, that measures of quality of care at the end of life exists and are evolving or exist and are being improved. It's not like there isn't something. How's that?

DR. LEWERS: It's just contradictory when you look at the two sentences. They just totally contradict each other.

MR. SHAPIRO: I think what I need to explain more carefully is that there are some measures that are very good now. It's kind of a spotty and inconsistent field. Some

measures are very good; others are being developed. Many of them are ready for use in a quality improvement mode, but not in an accountability mode.

DR. ROWE: They exist and they are being extended or improved or enhanced or something.

DR. WILENSKY: Or actually just some of the discussion that you just included about they may be useful or appropriately defined for some purposes but not for others.

DR. LAVE: I have a question and this is, I hope, not a red herring, but it's something that I find extraordinarily confusing. Jack, you're here, so I guess I'm raising these to you as much as anybody else.

We use the word dying and we use the words end of life. Are they the same thing? Now, the other reason that I come to this is that I had a long conversation with the people from support and they, for instance, were talking about how the cancer model is so different from these other models, and some of these other models have a three-year time frame over which they're kind of bouncing up and down, which in point they may die during one of the down, but they may bounce up again.

They may not consider themselves at any time over this process as dying except when they're in the down frame. But there is a time when you start worrying about the continuation of these people and I keep getting very concerned about what do we really mean.

Do we mean people who are dying who you have some sense? I just don't know whether they're the same or they're different, but what I'd heard Joanne talk about, the fact that you have people with COPD and they're dying, but they may not die for four years except they may die -- it seemed to me they weren't 100 percent sure whether you're talking about good chronic care or good dying care.

MR. COSGROVE: I think it's all just semantics, very subjective. On the simplest level, you're dying as soon as you're born.

DR. ROWE: I think that the clinically important thing I would say is the care requirements of the individual. If you group individuals who are dying or entering the last stage of their life, they have certain commonalities of care requirements.

There are people who are dying who have no care requirements. Somebody can be said, you have a brain tumor

and when it gets to a certain point, you're going to have a seizure and have sudden death, but up until then, you're going to feel all right. You'll have an occasional headache. You're not in a hospice. You're up walking around, but that person is at the end of their life or dying.

That's not what we're talking about. What we should say, something in the beginning saying that there is a group of patients who are requiring progressive -- because it increases over time -- substantial health and social support, medical treatment at the final phase of their life, or something like that. That's the group we're talking about.

That includes not only patients with cancer, but that, in fact, includes patients with degenerative neurological diseases, different models, ALS, et cetera, and it includes people in congestive heart failure or lung disease who, in fact, have agreed they won't be intubated.

It includes people with end-stage renal disease who have taken themselves off dialysis and who are dying. It includes a whole variety of different patients and each group has a different trajectory. So we have to define it

functionally.

DR. WILENSKY: Is it always progressively more resources needed? Again thinking back to the pattern that Joanne was showing us --

DR. ROWE: I think that's a good question, Gail. Maybe we should say often progressive.

DR. WILENSKY: Because it struck me that -- I mean, the nature of what made part of this population so difficult to identify is the variation and the unknown point at which they were likely to expire.

DR. ROWE: I think that's very good and that happens very much with AIDS patients. I mean, everybody thinks they're going to die and then you respond to an antibiotic for some infection, boom, they're gone.

DR. CURRERI: Congestive heart failure and COPD are exactly the same, too. They come in and they get intubated and everybody thinks the COPD person is going to die and three weeks later he's out.

DR. ROWE: The greatest example is Karen Ann Quinlan. They took her off the ventilator and she kept breathing for years.

DR. KEMPER: I think it's important to relate this

to our earlier discussion about risk adjustment related to disability because there's an overlap between this population and the population that is a high degree of functional limitations.

So to some degree, those payment issues we talked about before seem to me related to the care at the end of life as well, obviously in a loose way.

DR. ROWE: I have one other question on this recommendation before we're done. We had some discussion about whether or not HCFA should require some education in care at the end of life for residency programs that were supported by GME, since its Medicare beneficiaries were dying, we want them to get the right care.

The retort to that was, well, the ABIM is requiring it or the such-and-such different -- I understand that that didn't reach the point of consensus, but actually it didn't even reach the point of mention.

DR. CURRERI: It's in recommendation two, isn't it? I mean, I read that in recommendation two.

DR. ROWE: That's the one I'm looking at which is to sponsor projects to develop.

DR. CURRERI: I was thinking on the research on

the care of work with private organizations since they educate the profession. I read educate the profession exactly the point you were making last month.

DR. ROWE: But it doesn't say require it.

DR. NEWHOUSE: Jack, aren't you nervous about HCFA specifying requirements for medical education?

DR. ROWE: Yes, I'm nervous. I'm nervous at the reaction of my colleagues in the field. I'm just trying to provide better care for people who are dying who are Medicare beneficiaries. I'm trying to find some way --

DR. NEWHOUSE: The issue is what doors you're opening.

DR. ROWE: I understand. I'm just trying to get it in the narrative. We've got to do a better job at this.

DR. CURRERI: Then you're going to have to have some sort of regulation that says how much, how long.

DR. WILENSKY: Why can't we just have some discussion in the text that this needs to be a part of a curriculum without having -- I mean, it's not a specific thing.

DR. ROWE: Maybe something like one issue that has been raised in the discussion has been the feasibility or

appropriateness of, or something like that.

DR. WILENSKY: We can talk about the need for something to happen without having it in the context of a recommendation or a directive.

DR. ROWE: That's fine. I would that we were at least moving in the right direction.

DR. NEWHOUSE: I would think even necessarily a regulatory solution.

DR. WILENSKY: By all means not a regulatory solution.

MR. SHAPIRO: The last recommendation is a consolidation or summary of the ones that I had mentioned before which were repetitive really of an earlier quality one, so I thought this would sort of serve as a placeholder for this topic, and then the specific points are in the text now in the chapter itself.

DR. ROWE: The only other point I had on this was that we had some discussion about the fact that there's a palliative care DRG that's under demo, and I thought we might include it in the chapter, some comment about the fact that it does exist.

MR. SHAPIRO: I actually hid that in a footnote

that was obviously well-hidden.

DR. ROWE: I missed the footnote. I'm sorry.

MR. SHAPIRO: It's on the bottom of Page 3, footnote one.

DR. ROWE: Oh, yes.

DR. WILENSKY: Would you rather have it within the discussion?

DR. ROWE: Well, I asked that it be included and it was included, so I guess I can't complain.

DR. WILENSKY: We can think about whether -- which way is most appropriate, whether to have it as a footnote or to bring it up as part of the discussion.

DR. LAVE: I think it should come up in the text.

MR. SHAPIRO: Easily doable.

DR. LEWERS: Looking at this, it just hit me that the motive of managed care planning is -- I guess that does improve care at the end of life because of the terminal crisis. I think that's where you're heading. Well, it just bothered me that that's not really part of care at the end of life, but I guess if you're just isolating it to a terminal event, it is.

DR. WILENSKY: One of the problems that has

happened that I was concerned about when this was raised while I was at HCFA is that the current provisions almost assure that the main time this pops up, unless somebody makes it an issue before that, is when you're in an event, which is probably the worst time to be having this discussion. So I think the intent, which I very much support, is this ought to be part of a non-crisis discussion.

DR. ROWE: I think people have to understand what actually happens. I just finished a month as attending physician in the medical intensive care unit at our hospital on rounds six days a week with the house staff, which everybody can be happy they didn't sick the last month, and every morning when I would come in on rounds, there would be a couple new patients on a ventilator who probably shouldn't be on a ventilator.

The reason that they were on a ventilator and they were transferred from a nursing home and they were irreversibly, irretrievably ill and had advanced cognitive impairment syndrome, but nobody knew at the time they rolled into the emergency room what the intent was. The people in the emergency room don't have time to flip through a big

record. They either have to intubate the patient or not.

Then the house staff in the ICU is stuck because it's hard to withdraw that kind of therapy as opposed to withhold it. So we need to really --

DR. LAVE: Why don't we get medical wrist bracelets?

DR. NEWHOUSE: This sounds like a systems error.

DR. ROWE: This is identified by the support study and it's a systems error, that most of the time the advance directive is in the nursing home record and doesn't get transferred to the hospital with the patient.

DR. LAVE: You can have a Medic-Alert bracelet. I am allergic to aspirin and I would like to not be intubated.

DR. ROWE: That's right, do not even think about intubating me. I think that this is a very significant expenditure issue for Medicare. If HCFA is looking to save money, there are lots of --

DR. NEWHOUSE: Maybe we should cross-reference this in the error chapter then as this is an example of a systems problem.

DR. WILENSKY: It is. I mean, it's more than that. For many people, it's not a problem of not getting

the right information to the emergency. It's that nobody has ever had this discussion. But it certainly is also a problem sometimes.

DR. ROWE: Physicians are very bad at this. I think that's part of it. Part of it is physicians never bring it up even with cancer patients. It's hard to imagine.

DR. WILENSKY: But I think it would be that there's undoubtedly a systems error problem involved in this as well and getting the right information to the right place.

DR. LEWERS: I think my problem is that we've got four recommendations, one of which basically has minimal to do with improving care at the end of life, except at the very terminal event, and I don't want people thinking because they're doing this, that they are basically doing something in this total sequence of the end of life. Maybe you could just mention something along that line in your text.

MR. SHAPIRO: My conception is that the advance care planning is not necessarily restricted to what to do in an acute and terminal crisis, but also what to do over the

three years of the last stages of CHF or COPD and how to handle care as it comes up and how to meet palliative care needs along with doing curative things, which is something that I think is not really well understood or defined, but it's just something we need to start looking at.

DR. LEWERS: I think you need to put that in your narrative. I have one other point. One of the very important parts is the hospice care. We don't dwell on hospice care as much in here, and should we have something in here about hospice care?

Should we have something in here about getting rid of the six-month requirement and what happens if someone gets into it and then suddenly their disease doesn't progress as you would anticipate it's going to progress and they get better and they have to come in and out. All of this is part of providing that care.

I don't know if you want a recommendation, but I think it should be in there.

DR. WILENSKY: I think the discussion, though, actually is very good in the chapter about that.

DR. LEWERS: I'm talking now about the six-month element that I'm concerned about. Should we say something

about that?

MR. COSGROVE: What would you want to say?

DR. LEWERS: I think it needs to be revisited. When you started hospice and you had a six-month timeframe, it was a six-month timeframe. Now many individuals are still alive at a year-and-a-half and we want to make sure that they're not being discriminated against or cut off from support systems, et cetera.

MR. COSGROVE: I think that would be quite a minority situation, at least from talking -- some of the people I've talked to have said that the average length of stay in hospice is, I think, around less than two months.

DR. NEWHOUSE: 38 days, I think.

MR. COSGROVE: 38 days. The sense that I got is there's something of a fear of having that situation arise with inspector general audits that have happened in the last couple of years, anything that would come up like that and end up looking like that on the record.

DR. NEWHOUSE: I think that's why Ted is raising the issue.

DR. LEWERS: That's exactly why I'm raising it.

DR. WILENSKY: But I think at this point, I don't

think we're in a position to say what we would put in its place. As I read what was in the chapter, it's that there's a 60-day and then there's another 60-day or 90-day and then a follow-on 60 day, and that while technically you can re-up on the 60-day intervals, there is now some concern as to whether physicians are reluctant to indicate in this terminal phase as to whether they'll be challenged by the inspector general.

But it's really hard, I think, for us to go in at this point and make a recommendation about what we would like in its place without really having done some thoughtful work. There is not a lot of careful analysis about looking at the costs expended in hospice versus non-hospice.

I think this is a fine issue for us to try to get into next year, but I don't think we're in a position to make any kind of a recommendation now.

MR. COSGROVE: Because the cost reports begin for fiscal year '99 with hospice. There haven't been cost reports since '92. That's a new thing and as those come in, that's something the staff can look into definitely.

DR. WILENSKY: I think it's something that we definitely could have for next year. I just don't think

we're in a position to say anything.

DR. ROWE: I just want to say that over the two years that I've been involved in this activity, the amount and the content of the quality of the discussion and what we're doing with respect to this issue has, I think, increased dramatically. I think it's a lot of credit to you guys. Much more involved with it on the part of the commissioners in this issue than we had when we started.

DR. WILENSKY: Thank you. Contrary to what I said earlier, we're going to go to the informed consumer choice section and then move on, I hope, in about a 30-minute period to our last section for today which will be on graduate medical education. We'll do public comment before we go into GME for the sections that we've done.

MS. PHILIP: The first two recommendations relate to actions that the Congress could take to support HCFA's beneficiary education initiatives.

The first one is to provide the secretary with more administrative flexibility by relaxing its legislative requirements, especially in relation to the content of the information materials and the means of dissemination. The second recommendation relates to funding sources.

Congress can create a reliable source of adequate funding, specifically through the appropriations process as opposed to assessing user fees on the Medicare+Choice organizations. I don't know if you want to discuss these first before we get into the last four.

DR. WILENSKY: Why don't we discuss these first two. My sense has been that some of them will require more discussion than others.

MS. NEWPORT: First of all, I was astounded at the amount of information you put in the chapter. Education obviously was -- you were bearing that well in mind. Allowing HCFA more administrative flexibility, I guess, I'm struggling with the term basically.

Under the law, they're asked to do lots of things and measure lots of things and describe lots of things. I think some of that was self-imposed by them and I'm sure that even I know some folks in Congress are very concerned about the scope and where they went with this because it was sort of as if you asked someone if they'd like more information and you say, well, sure, because to do otherwise kind of casts you in the wrong light. I don't want to know anything, so you're not going to say the opposite.

But I think that the point being, and I'd like more emphasis on what do beneficiaries need? They need easily accessible information when they want to look at it, and that means when they're trying to make a decision on changing plans or they're looking at benefits changes and that sort of thing. That's our experience.

They don't want to be inundated with a lot of data that may not be useful for them at that moment in time. Just like when we look at our own benefits that we are supplied by our employer, what are we really looking at at that point in time and what do we need to look at.

I, frankly, do not read my material when I get it. I look at it when I need to go to the doctor. I look at it for different reasons. So what are we really defining here in terms of need?

So when you say more flexibility, to me in a regulatory environment, that speaks of asking for more information. I think we'd better be very clear that maybe HCFA should have some choice, excuse the expression, in what they give people that is more defined to what people need as opposed to more choice in what they need to get, because we've known that casting the net out as broadly as possible

has not been a very good outcome.

It's tended to confuse people, it's tended to waste money. I will say I'm fully supportive of your second recommendation as full disclosure here. My company has funded about 17 percent of this program, somewhere between $17 and $20 million.

I don't think I got what I paid for, if you will, and I think that we all acknowledge that there was a lot of struggle going on with what to do and when to do it, but I think that some of the problem in this was constrained or pushed by the type of arbitrary deadlines that were set in order to meet statutory deadlines of when the information should be put out.

That pushed a lot of pressure -- put a lot of pressure on plans, put a lot of pressure on HCFA, and I think in seeking the perfect, I think Jack's expression applies here. We really didn't come up with the optimum outcome. But I think that we're starting to go in the right direction.

I would just like to see flexibility, redefine that a little bit and I would make that suggestion here in terms of allowing HCFA to sort through options to give

folks, but don't have to give every option.

DR. WILENSKY: Let me see whether -- I'm not sure if I understand, Janet, what you would like as a change. The notion, as I read what was in this paper, is that the BBA was very prescriptive in terms of what HCFA must provide in the way of specific kind of information and what you're suggesting is a little more flexibility on HCFA's part as deciding whether -- basically being able to do what you suggest, which is to decide whether all of the information that was prescriptively required is really necessary.

So that seems consistent with what is in there. I guess the only comment maybe would be to include, alongside of the text, that administrative flexibility might allow less to be provided, rather than only more. That sort of says enough, that the flexibility ought to be able to allow HCFA to vary in all directions.

MS. NEWPORT: I would contend that HCFA had some flexibility already in the pure sense, but that's neither here nor there now. But I think they're going after everything and they really --

DR. WILENSKY: That's a different issue which either -- I don't know whether it's raised elsewhere -- one

is that HCFA might not be able to not do some things, but if it has the flexibility, that doesn't mean you're going to like what they do. We had talked about the reliable funding source separate from the user fees.

DR. CURRERI: This relates to the second recommendation and I'm more concerned with the text supporting it than I am the recommendation itself. I had a couple problems with it. One is that we seem to -- the tenor in this part of the discussion seems to be that the government has to provide everything for everybody and I can envision, particularly if you look at the bottom of Page 13, that you could have 5,000 different languages that were spoken and therefore conceivably you'd have to have 5,000 different options available in various languages.

We don't ever talk about what the family responsibilities are or the potential of using beneficiary advocates instead of trying to publish all of this material to try to hit everybody. Then we go on and talk about the frail and the elderly.

Sure they have some problems, but it seems to me that there has to be -- it isn't just a government responsibility, that there needs -- the whole tenor of this

is that the government has to take care of everybody. It seems to me there are responsibilities of organizations like AARP and others that could contribute here and that all options don't have to be covered by the government. That's one of my concerns.

Then the other one is that in here, there is, to me, the absolute expression that health care, under the Medicare system, is a right.

DR. LAVE: Is what?

DR. CURRERI: That health care under Medicare is a right of all citizens and if that's true, we ought to state that. But I think that what we're saying here is that with all these diversities, we have to deal with everybody's right. We have the same problem when we talk about two languages in a school or three languages or four languages depending on who's attending the school.

Somewhere there has to be a limit and then there has to be personal responsibility to be able to get this information. I didn't get anything in there of where the other responsibilities both individual responsibilities, family responsibilities, community responsibilities, organizational responsibilities come in.

I don't think it's reasonable to expect the government to provide all of these different options to educate everybody appropriately, particularly with differences in education and so forth. I just think the text needs more of where support could come from other than the government.

MR. SHEA: I actually rather like the way this text read in terms of this administrative flexibility because I thought it made the point rather than say we know exactly what's needed and here it is and go do this by this date. I got the sense here that well, we'll learn more as we go along and the department needs to have the flexibility to get a system that does it right. You know, give the right information at the right time, not overloading people and not just relying on sort of pieces of paper. So I actually liked the way it was drafted.

On the point that Bill just raised, I think it's absolutely right that this can't just be done by a Federal Government sort of action, but the problem we have with this group as we introduce the notion of people choosing based on information is, they're not a group. At the HBP, these people, most of them belong to a professional association or

a union. They have their employer, Ford Motor.

They spend a lot of money giving people information, the UAW. There are organizations that have responsibilities to those people as part of the organizational being. In this case, we have sort of the ultimate non-group situation and it really does pose a challenge. As AARP grows, maybe we'll solve this problem.

DR. WILENSKY: I was going to say, most of them belong to AARP. It can be part of their problems, too.

MR. SHEA: We're expanding our retiree's program, so maybe we'll be...

DR. WILENSKY: Why don't you go on?

MS. PHILIP: The next two recommendations relate to how the secretary could build an education and information infrastructure over the long term. The first one is to define and update and then require the use of standard terms to describe coverage options.

Both HCFA can use these standard terms as well as require Medicare+Choice organizations to do the same. The secretary could also encourage Medigap carriers and others who disseminate beneficiary education materials to use these standard terms that they define.

The second one is to develop and promote the use of decision-making tools to help beneficiaries process this vast array of information.

MR. MacBAIN: On the first recommendation, I read this, I recall reading just a few pages earlier, the description of HCFA's first attempt at a handbook that was confusing generally, unhelpful, required clarification, messages weren't readily understood.

So along with this recommendation, I'd like to see some text that gets into ways of testing the utility of the standard terminology. It's not just a matter of standardizing it, but developing terminology that's understandable. That's even more critical given the statistic that 40 percent of the people this is intended for won't be able to read it anyway.

MS. ROSENBLATT: I think the standard terms, to add to what Bill said, I think it's going to be tough, but it could be worth exploring. I also want to express compliments on the rewrite of the chapter versus our last meeting.

I was very, very happy about the way the standard benefits was treated based on the discussion. I thought the

chapter did a great job of pointing out the problems with standardizing benefits, particularly in the appendix. So that was terrific.

I have an issue that I didn't raise on the decision-making tools that affects my company. When we think about doing decision-making tools to help people decide among options or decide among products that we offer, we're always concerned about sort of going too far and ending up with some kind of legal liability for pushing somebody in a given direction.

I don't know. Maybe we need a caveat here. I'm not an attorney, but it just may be something to think about.

DR. WILENSKY: Any other comments on these? You want to proceed?

MS. PHILIP: The last two recommendations deal specifically with how to foster consumer protections. The secretary should closely monitor marketing practices of Medicare+Choice organizations and then specifically study vulnerable groups and their informational needs, their informational use, and their enrollment patterns.

DR. NEWHOUSE: This is along the lines to Bill and

Gerry's exchange on vulnerable populations, but my reaction to this was this recommendation needed some perspective. There's lots of choices that the Medicare population has to make. Most importantly, they have to make choices about treatment options, they have to make choices about what provider they're going to go to. They have to make a choice about Medigap. You discuss Medigap, but not exactly in this context. And they have to make a choice about plan.

Now, arguably, treatment options and provider choices are at least as important as choices about plan, but we don't say anything about that range of choice or about vulnerable populations' potential problems with making that range of choice.

If we're talking about devoting resources to improve decision-making by vulnerable populations, I'm not persuaded that it's best directed at the choice of plan as opposed to other choice options they might be making. That gets again back to what is the role of government in facilitating choice.

I think what I'm looking for, I think, would be some perspective in the text that choice is, in some sense, pervasive, and it's not just limited to choices about plans.

MS. PHILIP: The choice of both treatment and providers?

DR. NEWHOUSE: Yes. You bring up the Medigap example, but not in the context of -- I mean, that's also a choice. You bring up that they have to choose Medigap, but it's not kind of -- that's really separate from the discussion of the vulnerable populations or what we have done to improve choice there for vulnerable populations. I'm not sure we've done much.

MS. DOCTEUR: Joe, I wonder if tying this also back to some of the concerns you raised at a previous meeting regarding the selection issue may have come into play here regarding studying the enrollment patterns of vulnerable populations to see whether they differ than others and whether there's any selection issues there.

DR. NEWHOUSE: They're potentially related, but I think I can distinguish them. The issue of what information people have and how they're choosing is -- as I say, I was looking more for the point -- your point is fine, but I think the notion in the chapter when we're talking about structuring beneficiary choice, the choice goes beyond choice of plan and it applies to both within plan and within

the traditional Medicare. There's lots of important choices people have to make.

DR. WILENSKY: And more there's this concept that we sometimes act as though only with the adoption of Medicare+Choice do we have a need for information so that seniors know what they're choosing. But it's basically throughout the system whether or not they go into the +Choice world that they have these needs.

DR. NEWHOUSE: Do they go into a nursing home, for example, or when do they go into a nursing home.

MS. ROSENBLATT: The only comment I'm going to make and maybe being too sensitive here because my company sells a lot of Medigap policies, but in the text when you go through the discussion about what led to the Baucus amendment and OBRA, at least as I said I may be too sensitive, but I kind of felt that you were left with the impression that all the carriers and all the agents that sold these products were kind of doing very bad things.

It would be nice to have a sentence there that some carriers were doing the right thing.

DR. CURRERI: I don't know whether it's one or two, but it's the recommendation the secretary should study

the enrollment patterns of vulnerable groups such as low-income beneficiaries to assess whether their informational needs are adequately met.

I'd like to take out vulnerable groups. I really think the secretary should study the enrollment patterns of the whole Medicare population, and I can tell you that I counsel a lot of people making choices in Medicare and who can read, who are not frail, who are not elderly, and who are very confused as to their options, and by and large, when it really gets down to it, even though I try to explain all the options to them, they say, well, what should I do. Just tell me and I'll do it.

So I really think we need to look, because my guess is that many people are going to their physicians or their employer or the union or somebody and saying, tell me what to do, and not sitting down and trying to study all of these options.

So I think we really need to study, because that's one way of choosing your options when you become Medicare-eligible. Maybe there are ways that it can be presented to these people, but I don't think it's just the vulnerable populations. In fact, I think the vulnerable populations

probably have an easier time because the children are making the decision and they can make decisions a lot better than those reaching the age of 65 and suddenly are overwhelmed by all these different opportunities.

DR. WILENSKY: Bill, a lot of the children are 65.

DR. CURRERI: That's true. But at any rate, I just -- I didn't like the emphasis on just the vulnerable populations because I don't think that's -- I think the problem is widespread.

MR. MacBAIN: What Bill just described reminded me of one of the earlier recommendations on promoting the development of interactive decision-making tools because Bill is an interactive decision-making tool. And that role of physicians, in particular, but also children and other advisors is crucial, I think, and that we may brush by that a little too much in the text.

The role that HCFA could play in providing materials that could help in human interactive decision-making tools interact in a way that helps people make decisions, I think, may be the useful thing that can come out of this. You didn't know you were an interactive decision-making tool, did you?

DR. WILENSKY: Any further discussion? Thank you. We're going to move to the last section for the afternoon. Excuse me. Let's go to public comment on what we have done from the renal -- anyway, any of the public discussion that people would like to raise now for the last several topics.

MR. LISK: Good afternoon. Today we're going to continue our GME deliberations and expand upon a discussion we had at the last meeting. If you recall, we walked through -- we talked about options regarding Medicare direct GME payment and direct medical education adjustment and at that meeting, Joe discussed the basic economic principle of apprenticeship training.

But if you're getting training that is useful anywhere, the employer has no incentive to pay for it. The trainee bears the cost of that training in the form of lower wages.

To implement this concept, the commission then discussed moving what we now label direct medical education expenses into patient care costs and recalculating the indirect medical education adjustment to reflect this shift in cost from one payment to another.

What we want to do today is continue that

conversation, review the basic conceptual construct, including the implications this approach has for Medicare payment policy, and the commission's GME report, and also consider some of the issues that will need to be addressed if the commission adopts this approach.

Hopefully you can come to some consensus or decision on whether you want to adopt this concept for the August report. So let's move on to the first slide concerning the conceptual framework.

First the basic theory says in competitive labor markets, a rational employer will not pay for general training. The basic concept in apprenticeship training is that the employer derives no direct benefit for providing training if the employee can leave the firm and use that training in another setting. Therefore, the employee pays for the training.

Residents pay for their training by providing services and accepting lower wages than they could earn elsewhere. Their pay reflects the value of those services they provide minus the cost of their education. Medicare's direct GME payment then represents Medicare's share of the value of resident services.

I provided a simple chart that basically reflects what's going on. Basically the patient care services being provided by residents equals the sum of the residents' salaries and benefits plus the cost of training, in principal. This right-hand bar is what we observe as direct GME training costs.

Residents' salaries in this model are a function of the product they produce and the cost of training in the institution. If the cost of training is greater than the value of the services, then the trainee would pay a tuition in that circumstance.

So what are the implications of this concept for Medicare payment policy? Well, first is that the cost of services provided by residents should be recognized in patient care payments rather than as a separate education payment. Residents are providing services and those have been left out of the cost base for what we are paying for in terms of inpatient payments.

Residents are paid a salary because they provide patient care services. Excluding them from patient care payments underestimates the cost of providing patient care services for patients in those facilities.

Second, the higher cost of teaching hospitals potentially should be recognized in DRG payments if they reflect more severe case mix or more advanced care, a different product from other hospitals. And in effect, what we're including when we consider residents' costs, some of what residents are doing are like physician-type of services, so we're talking about somewhat of a different product also being produced in a teaching hospital from another hospital.

Third, it also implies that the training in workforce issues in this concept are distinct and separate from patient care payment issues. Currently under the direct payment, we have these things integrated into the direct GME as a workforce payment or what is it. So this has implications for Medicare's involvement with workforce policy. It reinforces the notion that Medicare's primary responsibility is for providing patient care. It potentially leaves workforce issues off the table for Medicare.

Now, if Medicare has payment biases that might affect the workforce in some way, those could somehow be factored into the payment in those situations. But in

general, we're talking about workforce as a separate issue here, a way for Medicare payment policy.

So how can this concept be adopted into payment policy? Well, we must recognize that residents provide patient care services and in that they're a value for their services being provided, and we've identified three basic ways of doing this.

First basically is the status quo in terms of what current Medicare payment policy is where we consider the direct GME payment as a payment for services being provided by residents. In essence, we are just renaming the current payment from an education payment to a service payment.

A second approach would be to bill for the services provided by residents directly. To the extent that residents provide additional services to Medicare patients, providers could be reimbursed for those service costs directly.

A third approach, and that's the approach the commission discussed at the last meeting, is incorporate direct GME costs into the indirect medical education adjustment.

DR. NEWHOUSE: Craig, clarification. Can't

residents bill directly if the institution does not accept GME payment?

MR. LISK: The residents, if they are a licensed physician and not in a training program, can bill for services for the institution in terms of when they are moonlighting. But they're not in the physical presence of a training program at that point in time.

DR. NEWHOUSE: I thought, at least at one time, they were allowed to bill directly if the institution didn't accept GME payments. No?

DR. WILENSKY: That's consistent, though. That would be effectively not being in for payment purposes a training program.

MR. LISK: Probably, if they wanted to be excluded from direct and indirect payments.

DR. NEWHOUSE: The institution just declines the payment.

MR. MacBAIN: Somebody bills.

DR. NEWHOUSE: Yes, somebody bills.

DR. ROWE: It sounds like an institution can accept GME payments institutionally and give a resident, if he or she happens to be moonlighting at the time.

DR. NEWHOUSE: Yes, away from the institution. I wasn't raising that issue.

MR. LISK: I don't know if someone is aware of cases of that situation.

DR. NEWHOUSE: I'm not sure it's ever happened. I just thought it was open under law.

MR. MacBAIN: It's interesting because to get back to the original argument on this, is there a way that we can estimate what the market value, if there is such a thing, what the resident services would be if they billed for them versus their stipend because that would give us some sense of this equivalent tuition that they're paying by accepting less income.

DR. ROWE: I hadn't seen this recommendation before, per se, but given the amount of paperwork associated with billing Medicare and the increasing concerns with respect to fraud and abuse and reviews and audits and threats of criminal prosecution, I mean, residency is hard enough, Craig. To have people now start billing for every service that they provide doesn't seem to me to be overwhelmingly attractive. I haven't heard what other unattractive options you have, but certainly -- this is

supposed to be a training program.

MR. LISK: It's one way of theoretically financing it.

DR. WILENSKY: And I think right now we ought to look at this as that in principal, these are options.

DR. ROWE: Theoretical options.

DR. NEWHOUSE: I think they're more than theoretical. I think they're actual options now.

DR. LONG: Don't you think billing would be good training for all of those audits that come later?

DR. ROWE: That's a good point.

MR. LISK: The third approach again is incorporating resident costs into the IME payment formula in some way and that's what I'm going to concentrate most of my discussion on this afternoon.

DR. WILENSKY: Unless you would like him, Jack, to concentrate on --

MR. LISK: I could go back to the billing stuff if you'd like, but that seemed to be some of the directions the commission was leading to, but I wanted to make sure that you had at least what we thought of as the ways we could think about implementing this concept.

So first I want to just go on and talk about the advantage of incorporating these costs into the IME adjustment. For one, it would clarify Medicare's role in that Medicare pays for patient care services. It would get rid of this distinction of what these costs are as direct training costs and I think it would potentially help clarify things in terms of what Medicare's role is here.

Second, for many people, this would be considered a benefit; for some it may not, the second option. It would reduce variation in payments across providers, improving payment equity across providers and creating better consistency in payment policies within the Medicare program, which has moved over time from facility-specific payments.

The direct payment currently is institution-specific payment amount based on historical costs. Now, when you do this, of course, you're going to have some variation, so the variation would be reduced. So some people are not going to consider this as an advantage because they're going to lose on that side of things.

So I just wanted to mention that. But in general, in terms of payment consistency within Medicare's principles, it would be considered an advantage. Third, it

would support teaching hospitals to the extent they provide additional patient care value consistent with the current payment system.

But what are the potential disadvantages? Well, for one, it would continue to link payments to residents. Implicitly there still will be a per-resident subsidy provided by Medicare which may affect hospitals' decisions on the number of residents they train.

DR. CURRERI: I thought under the BBA you can't increase it.

MR. LISK: It's still the marginal resident. Even though there's a cap, you still have how many residents you have. So you still have the incentive to be potentially up to the cap versus what is the right product mix for what you think you should have in your institution, which may be less than the cap, it could be more than the cap.

DR. CURRERI: In other words, the inducement is a financial inducement?

MR. LISK: There still would be a financial inducement there because you're paying on a per-resident basis, is basically what we're saying.

Secondly, payments would be only -- in initial

concept, payments would only be linked to inpatient payments. It does not address payments for residents' services furnished in other settings, in dealing with the ambulatory training sites and such.

So now I want to move on --

DR. NEWHOUSE: Craig, just in terms of writing a chapter, disadvantage seems to me has to be relative to some counter-factual. I think these statements you've got are right, but they're not -- disadvantage seems to me to be something that well, relative to the status quo or whatever the alternative is, this would make it worse.

DR. WILENSKY: It's implications.

MR. LISK: I think you're right. There's some aspect of this. On the second point --

DR. ROWE: These are other features.

MR. LISK: Well, there's other implications. There tend to be disadvantages in the current system is how I was doing it out. It continues those things.

The second one, theoretically, it may make it a little bit worse.

DR. NEWHOUSE: Disadvantage has to be relative to some specific and this is sort of relative to an ideal,

whereas the advantages are relative to the current system. So I think you've got to maintain it relative to the current system.

MR. LISK: Point taken.

DR. KEMPER: Craig, the second point, that it's limited to inpatient payments, I don't see anything in the logic of this that says it has to be limited to inpatient patients.

MR. LISK: That's right.

DR. KEMPER: Let's say all the training took place in the outpatient side or even outside of a hospital. At least the abstract logic of this says you could have the payments go wherever the training took place.

MR. LISK: Right, we have to develop that. Part of the problem is developing that construct. What we currently have is a way of doing it within the inpatient system easily.

DR. WILENSKY: It's not where the training takes place. It's what is affected -- where the costs are affected.

DR. NEWHOUSE: The issue is, is the outpatient care different in the teaching setting than the non-teaching

setting.

DR. CURRERI: I think, as I mentioned to Joe earlier, I've tried this idea out on at least a dozen chairmen of departments of various medical schools and really most of them are fairly enthusiastic about this because it would even up the disparity that we've all recognized as inappropriate.

DR. WILENSKY: He didn't try it out in New York, I bet.

DR. CURRERI: I tried it out in Pennsylvania.

DR. WILENSKY: Getting close. That's not New York.

DR. ROWE: They're too worried about their bond rating being downgraded to worry about it.

DR. CURRERI: But there is one concern and you mentioned it in your little memo here and that is a concern that as we go to more and more outpatient outside the hospital training facilities, that they're concerned about when you dump DME into IME and it all goes to the hospital. There could be a withdrawal.

I was wondering, and I defer to Joe on this, why couldn't we recommend that the DME be put into an IME

payment, but that portion of the IME payment be paid to program directors who are making the decisions on which ambulatory facilities and let the IME going to the hospitals stay in the hospitals for inpatient care.

DR. NEWHOUSE: I don't think that works. I think the IME is inherently an add-on to the DRG.

DR. ROWE: I'd like to respond to my distinguished colleague from Alabama if I can with respect to one aspect of this. That is that not even commenting on the proposal to send the payments to the program directors, put that in the category of not rising to the bait, but I would like to comment on the issue about the outpatient because I think it is a very serious and significant issue and it has to be addressed.

The only countervailing factor -- there are two countervailing factors on this issue and I think this should be addressed in the chapter, Craig. One of them is that in many times, the outpatient facilities that the residents would rotate to are, in fact, owned, sponsored, or controlled by the hospitals. So it's part of the same. It's all fungible in a sense.

The second is that the residency review committees

that approve the residency programs increasingly have requirements, I think internal medicine is now 30 percent or something of the time has to be spent in the outpatient environment, and therefore, that's the assurance that the programs -- and the programs are reviewed regularly.

So if they're not robust or intact at least with respect to those requirements, they're not approved. If they're not approved, they don't have residents and they don't get any money. So there is some, in a sense, strong incentive for the institutions to have valid outpatient activities. I think those are the only factors and the material you distributed to us outlines this issue pretty clearly. I think those would be the only factors I would add. I think this is a good point.

MR. MacBAIN: Something that both deals with the terminology, but I think goes beyond that is if we accept the Newhouse epiphany as the starting point for this, we're not talking about medical education, direct, indirect, graduate, undergraduate. We're talking about cost of care provided by organizations that happen to also be training residents.

Some regression analysis indicates that there's a

correlation between training residents and higher costs that we're willing to recognize in the Medicare program.

Using that as a basis, there's no particular logic to piggyback on the IME formula. It may be the logic underlying that, but the formula being tied to number of residents and being tied to only inpatient services is not necessarily the -- we're not bound to that anymore.

I think we might want to take a step back, stop using the terminology medical education, and start thinking in terms of costs of the kinds of institutions that are either training residents now or might in the future, and I'm thinking specifically of things like rural consortia that are left out of an IME-based model.

As I recall, that was anticipated in the Balanced Budget Act, so we really ought to be thinking in those terms, that if we're going to meld what we now call direct and indirect together into a payment for facilities that train residents, then we ought to be thinking across the broader spectrum of who is training residents or who may be training residents or who do we want to be training residents and then from that, how do we pay them.

DR. ROWE: If I understand it, rather than medical

education payments, we're really talking about supervised care payments or something like that.

DR. WILENSKY: No, we're really talking about equilibrating the costs and the fact that institutions who are involved in training have documented the entire cost.

DR. ROWE: I understand that. I'm just trying to think of how to conceptualize this as a category.

MR. MacBAIN: It's using the fact that an organization is training residents as some sort of a proxy for the fact that it inherently has higher costs, and we think that's good.

DR. WILENSKY: And different care.

DR. LAVE: I think that one of the problems that we're getting into is that we cannot have this conversation and have the conversation about how and where residents should be trained at the same time and the appropriate place for training residents because they're different issues.

So one of the things that one would say is that what we are talking about now has the possibility, if the Congress were to follow us, of taking the Balanced Budget Act and everything they have to say about training graduate medical education and throwing it out.

So it isn't --

DR. WILENSKY: Why?

DR. LAVE: Why? Because what we are doing is not talking about training and where people are training. What we are doing is talking about how to decide to calculate patient care of different settings and it could very well turn out that the patient care is very different. So we have to have a very different mindset, I think, and there are really, I think, two issues.

We are coming back to sort of a cost-based system, so we want to say, when we sort of re-estimate a cost add-on to certain types of facilities where we suspect the patient care may be different, what costs are we going to include, and if we do that, how are we going to allocate it. So that sort of is a first issue.

Then obviously there is a problem because some of the people where they would like to have costs don't currently have costs because they don't do what they want us to do, so we have a little problem there.

DR. WILENSKY: You're making really, I think, a distinction between Medicare as a payer to equilibrate cost differentials and somebody, Medicare or the Federal

Government or somebody else, being involved in workforce issues.

DR. LAVE: But I'm saying that what we're talking about now is not a workforce issue, it's a payment issue. So then we have to decide, how are we going to decide how much more we ought to be paying for those institutions which may be providing more services that we want to pay for because they're training, to come back to the Newhouse epiphany.

I think we can all kind of follow that through in a DRG system about how to do it. It's sort of harder to figure out how to do it in other settings, particularly since we may not be getting better patient care in some of those settings. We'd really just be doing a lot of subsidization of services.

So I think that to carry this through that we have to purge our ideas of the appropriate way of training and try to think about how we would determine what the additional patient care costs are for which, in fact, we may want to pay enhanced services for and carry that through, see whether we like the outcome.

We may decide, oh, my God, this is really the

stupidest thing we ever did going down this path. But to go down that path, I think that's how we have to do it.

DR. WILENSKY: Would you include in that distinction you just made that uncompensated care, for example, which increases institutions' costs, may or may not be something that we would regard as --

DR. LAVE: Right, but I think we're now trying to figure out what to do with the institutions. I think the uncompensated care issue, my sense is from where the commission came down before on uncompensated care, was that we decided it was not a cost issue, it was really a patient subsidization issue that we were tying to patient care.

So we did come into that a little differently saying we wanted to put money into these institutions because they didn't have the revenues to support things. So I'd say our conceptualization of the disproportionate care issue is a different thing from the current Joseph Newhouse epiphany reconceptualization of how we may want to think about the graduate medical education issue.

If we're going to say it's higher services, how are we going to measure the increased quality of services, which, in fact, we get, would take more money to the

hospitals that gives those which would be Mt. Sinai.

DR. ROWE: Mt. Sinai will be closed by then.

DR. KEMPER: I just have three comments. The first one is that Joe may want to have this renamed, giving the congressional debate that will ensue if it goes forward. I can purge sort of the policy discussion about where people ought to be trained, but I can't purge the fact that these payment policies will affect where people are trained. So I think it's hard to make that separation.

The third thing is, let's say -- this goes back to whether it's sort of the inpatient side of the hospital or the outpatient or other outpatient settings. If, in fact, the costs in the outpatient side are higher when training is going on, when residents are being trained, then it seems to me, if we don't include -- do something on that side, then the total cost of these extra services will be ignored because there's no way to put them onto the inpatient side of the hospital.

DR. LAVE: It's not the costs, remember, it's the services are better.

DR. KEMPER: That's right. Let's say 30 percent of the time and 30 percent of the extra costs are on the

outpatient side, if we ignore those, then we'll be underestimating the extra costs due to the training.

DR. WILENSKY: The cost of the different product.

DR. LONG: I'm not sure whether I agree or disagree with Judy because of the language that's being used. I certainly don't see this as cost-based. I mean, there are those things which are the additional costs of the educational process which, under the epiphany, are borne by the trainee.

Then there is this surrogate notion that where this kind of training goes on, we are producing a different product of presumably greater value, greater quality, and that cost we definitely -- well, I'm not sure if we definitely, but I think the consensus is that we appropriately should be paying for that.

In a couple of your things, Craig, and in a couple of the comments, clearly our tendency is to put this into the hospital mindset and say, oh, yeah, it works when you tie it to DRGs, but then how would you work anywhere else.

Well, if we believe conceptually that the process of medical education of the graduate variety, wherever it occurs, in fact, will occur conceptually in institutional

structures that will, in fact, lead to higher quality and newer techniques and all of the things that we believe enhance value which we wish to pay for, then I think it's context free.

Whether it be the various organizational structures that determine what constitutes an accreditable residency and where it has to take place and how its mixture occurs, seems to me that whether it's happening in a health plan or happening in an outpatient facility or happening in a skilled nursing facility or happening on the inpatient side really doesn't matter.

If you are, in fact, moving institutionally toward prospective payment and away from all cost-based payment, then the notion of a mechanic that supplements that prospective rate to pay differentially for the additional value and quality that you expect to happen coincidentally with the teaching activity makes perfectly good sense across all settings.

DR. WILENSKY: The implication is that wherever training occurs produces a different and presumably better product and there should be a different compensation?

DR. LONG: That's how I'm seeing it, yes.

DR. NEWHOUSE: That's not inherent. The question is, is the product on the outpatient side really any different.

DR. WILENSKY: I guess one of the questions is, if we make this presumption, will it behoove us or will we be required to demonstrate a differential product in any of these training sites for which we then ought to be willing to pay something different. Who has the burden of proving that there's a differential product being produced?

DR. ROWE: The whole question of the outpatient/inpatient is a different question than the central concept. It's kind of distracting us from the issue of do we buy that first premise, if you will, before we worry about the different locations.

DR. WILENSKY: We certainly have to go back to do we buy the first premise, but this issue --

DR. NEWHOUSE: Maybe we should talk about that because it makes it awfully hard to have a follow-on discussion unless we have some agreement about that.

DR. LONG: Is the first premise the notion of do we, in fact, get better product and better quality?

DR. NEWHOUSE: The first premise is are training

costs shifted to the residents. That's what I meant, do we agree on that.

DR. LONG: Are or should be?

DR. NEWHOUSE: Are.

MR. MacBAIN: Is that what actually is happening? I think it comes down in my mind to, if you look at the correlation in the IME calculations, if that correlation is so strong that we believe that there's really causation there, that simply having a resident adds those costs, then it's an education cost.

If, on the other hand, it's coincidental, that institutions that tend to have residents also tend to have higher costs because of the higher quality, because of the stand-by capacity, because of the more complex case mix, then those costs are payment for service.

DR. NEWHOUSE: I don't think that's right. The resident could be part of the different product. The fact that the resident is around at 2:00 in the morning means the product, in some cases, will be different than if nobody but the nurses are around at 2:00 in the morning.

DR. CURRERI: Could we look at this, Joe, in terms of trying to figure out what payment costs are in the DME?

Could you look at it in terms of replacement? That is, if you got rid of all the residents, what would it cost to hire nurse practitioners or family practitioners or whatever to replace so that --

DR. NEWHOUSE: You can ask that question. I'm not sure you can ever get an answer that anybody would believe to hold the product constant.

DR. WILENSKY: The problem, I think, is that, is it the same product or is it a different product, and if it's a different product, is it something that we ought to be willing to pay for?

DR. ROWE: We have had one experience that addresses that, in part, Bill. That is, in the State of New York, regulations were passed some years ago called Part 405 of the State Health Code which limits the number of hours a week that a resident can be in the hospital and on call or in the hospital, awake or not.

Therefore, what happened was that with the same number of residents in a program, there were fewer residents around at any one time and in order to try to maintain the same level of service, the institutions had to hire house doctors, if you will.

So there is an experience that does permit you to say, if there were a total number of resident hours in a hospital per patient per week, and then we reduced it by X percent, how much did it cost us to replace that, and those data are available.

DR. CURRERI: And your product was the same?

DR. ROWE: If we kept the product the same, which, I mean, how would you ever measure that?

DR. NEWHOUSE: That's the problem.

DR. ROWE: But we felt that the payment and attending physician complaints were no greater or worse than they were before. If we didn't do it --

DR. NEWHOUSE: The resident complaints ought to have been less.

DR. ROWE: No, the surgical residents are very upset because they feel the only bad thing about being on every other night is you miss half the good cases. But some of the other residents don't mind.

DR. NEWHOUSE: That was miss, m-i-s-s, as opposed to mess, m-e-s-s.

DR. ROWE: There are data for that and I can tell you that it's more expensive to replace the residents with

those kinds of doctors than it is to have the residents.

DR. WILENSKY: Which suggest that the trainees are bearing some of the costs.

DR. ROWE: Which suggest that they're taking a discount because of the general training value, which is Joe's theory.

DR. WILENSKY: I don't know whether -- I mean, this will only take us a very small step forward, but this issue of the notion that the trainees bear the cost of training. Is that something that people are comfortable with a working presumption, and then we can try to get to the next step of then what is the next requirement for exceptions in this thought process.

DR. ROWE: At some point, I'd like about five minutes to make sort of a statement about this.

MR. MacBAIN: I'm not completely comfortable looking at that by itself because we could conceivably say step one, yes, the trainees are bearing the cost of training through reduced salaries. Step two, we're just paying for service. And then step three, we're going to pay the same amount and you guys figure it out.

I think that's a problem because I don't think we

can go that far without saying no, these things are linked; that if on the one hand we're saying the trainees are bearing the cost of training, then we've got to do something with it with what we're now calling a direct medical education payment and not just let it dissipate.

DR. NEWHOUSE: It wouldn't dissipate.

MR. MacBAIN: That's what I'm concerned about. We could jump from that saying, okay, now we've covered the cost of training.

DR. NEWHOUSE: Now we've got a group of institutions that have higher costs and the question is --

MR. MacBAIN: What I'm saying is we need to accept that.

DR. NEWHOUSE: That's the second step. We've first got to accept that it is patient care costs.

DR. WILENSKY: You may go ahead and make your statement.

DR. ROWE: I want to say a couple things about this. I've thought about it a lot and Joe and I have spoken about it a bit and I spoke with Gail and Joe at the last meeting about it. So in the hope that it might be of some help to my fellow commissioners, I wanted to explain or

provide a little bit of context of what the implications might be of this.

I'm attracted to this idea intellectually. I respect and, in fact, envy Joe's understanding of these issues, so I think that this is a significant contribution to the debate or the discourse about graduate medical education.

I want to make sure that the commissioners are aware that there are two categories of institutions that are influenced potentially by this and what the implications are for those two categories of institutions. I do this because I think that some of you may not be aware of the two categories.

I happen, fortunately for this discussion and for me, to be the president and CEO of one institution in each of the two categories.

DR. WILENSKY: That means you can get hit no matter what you do.

DR. ROWE: I get screwed either way. That's right. It means I'm Newhouse epiphany-neutral.

Let me explain the two institutions to you because I think it might be helpful to you. I think that the amount

of graduate medical education payments that institutions currently receive is very, very dependent upon how the institutions evolved and how they got to where they are.

Depending upon which category of institution you're in, you're going to be a big winner or a big loser if this change is made. So I think we need to understand that. Let me give you two.

One is the NYU Medical Center, which has a very low GME payment and a very low number of full-time physicians who are paid. Therefore, their salaries don't go on the cost report. So they have a low GME payment. They have always held that attending physicians must train doctors and work in the hospital as a condition for their appointment to the faculty of medicine, and that is basically pro bono activity that the faculty does.

That's a group of hospitals which are characterized by hospitals that started as schools or that the school was always there and the dominant part of the academic medical center. Those institutions are elite institutions in many cases, but they have low GME payments because of the structure.

You go to fold this into the PPS or the general

payment and use a national average, those institutions are huge winners, huge. Okay. Now, 40 blocks away or 60 blocks away is the Mt. Sinai Hospital. It has had characteristically a different relationship. It started as a hospital, developed its medical school secondarily 30 years ago, has a large number of full-time physician faculty who are paid to supervise and train the residents.

Those dollars go on the cost report. The GME payments at Mt. Sinai Hospital are very large compared to other institutions. The difference in the physician salaries between the Mt. Sinai Hospital and the NYU Medical Center are $22 million a year.

DR. LONG: Aggregate.

DR. ROWE: For the whole institution. Neither of those hospitals -- both of those hospitals are functioning well, I believe, and neither is good nor bad with respect to each other. The residencies are very competitive with each other. You do this, NYU is a big winner, Mt. Sinai is a huge loser.

And in every city you're going to have that. I think USC is a big winner, UCLA is a big loser. I think Jefferson is a big winner and Penn is a big loser. I think

Brigham is a big loser and that Beth Israel is a winner. I think in Chicago I can name one or two. You're going to set up a situation with otherwise equivalent quality institutions because they happen to get to where they are by different pathways, that one would be a big winner and one would be a big loser.

If that is, in fact, the case and such an analysis could be done, but I think it has, and the reason, the rationale that supports is the complaint that people have of the variability of GME costs, well, this is the origin of a lot of the variability within regions of GME costs.

If you do something like that or if we do something or if we recommend that whoever do something like that, and I have no a priori objection to it, I think it's intellectually very stimulating, then I would recommend that under the sort of rubric of primum non nocore, above all do no harm, that we would recommend that we would phase this in very gradually along the lines of the capital change that was phased in gradually with some kind of exemption pool or some kind of other thing so that we got to where we thought we needed to be, but we got to it without a war, which is what you would otherwise, I think, induce.

So I just want to make sure that everybody understands there are those two kinds of things. I hope that's helpful and I'm sorry to take so much time.

DR. WILENSKY: I do want to say, I've said this in a number of other public environments and settings, that the issue of how we get -- if we can get some agreement on what we think would be a better system, the issue of how we get there and how long we get there is one that we will clearly have to discuss.

I was at HCFA for the capital payment shift and this issue -- I mean, it was an easy decision for me to say, not only meeting with every conceivable group and trying to respond to them, but having a ten-year phase-in was the price of moving ahead without having Congress block the institution of the regulation. I thought that was a price worth paying then and I think that now.

DR. ROWE: And you're two-thirds of the way through that or whatever and it's kind of a done deal and nobody even talks about it anymore.

DR. NEWHOUSE: You're 90 percent of the way through.

DR. LONG: I just want to, if you'll indulge me,

clarify that $22 million figure?

DR. ROWE: Right.

DR. LONG: That's an aggregate. Are the programs of comparable size? Are we talking about the same number of physicians supervising residents?

DR. ROWE: No, one hospital is larger than the other, but let me give you an example of what that means. What it means is, we have more full-time staff in the emergency room because we have an emergency medicine residency at one institution and not at the other.

If you go to the medical ICU of one institution, there are a couple full-time faculty whose salaries are paid in largely GME supported, whereas the attending physicians who are critical care physicians at the other hospital come in and pro bono go on rounds every day with the residents for a couple hours.

DR. LONG: They're there just as much --

DR. ROWE: Just as much but they're not paid, that kind of thing so it's different.

DR. NEWHOUSE: I think that Jack's exactly right on the transition. You would otherwise cause potential massive dislocations. But I think I would say that

everywhere, not just in hospital payment, also in how we treat, for example, practice costs in Part B, we in effect average everything.

We don't have something -- except that we have cost-based reimbursement which is, in principal, supposed to be a diminishing part of the program. We average basically here, even for things where there may be very different scales, economies of scale.

DR. ROWE: I don't disagree with that. It's just that this would be a sudden --

DR. NEWHOUSE: No, no. I have always thought if we went to this we would have to have a transition.

DR. ROWE: And we would have to take into account the regional differences in the costs that go into the payments for these services.

DR. NEWHOUSE: You could, in principle, I suppose -- I haven't thought this far ahead, but I think in principal, if you were doing this like we do the rest of PPS, you would put -- you'd have a factor price index on the salary. That would, in effect, fold into the wage index.

DR. ROWE: Anyway, I hope that's helpful.

MR. LISK: Do we want to move on because the next

slide gets to how we would consider --

DR. NEWHOUSE: Before you move on, let me say something about the outpatient setting. I think there is an issue. I think these are two different issues, but as training shifts to the outpatient side, my sense of outpatient training is that it is inherently more costly because there's more of the residents standing around watching than the resident doing things independently.

So those are real costs that somebody has to bear, presumably the resident unless there's a subsidy explicitly to the resident. But I think it's right to keep these two issues, try to keep them separate.

MR. LISK: I'll maybe get into a little bit of that, too. So in terms of what we need to consider is, first you need to consider how direct GME costs and payments should be integrated into a revised IME estimate, and there are a number of things you need to consider within this question.

There's whether we're going to be integrating what our costs from the cost reports or what historically we have paid. There's also an issue --

DR. NEWHOUSE: Can you say how those differ?

MR. LISK: They do differ. The costs are greater than what the payments are.

DR. NEWHOUSE: Because of the CPI.

MR. LISK: Because of the CPI and also how hospitals have shifted more to some more faculty salary. Support from volunteer faculties has dropped a little bit over time as faculty sizes have increased. Also is the age of the data and what year data we use.

In principal, if we're talking about what the Medicare-based payments are based on, we might want to consider going back to what the original payments were for doing this in the original payments, but I think the more recent relationship in terms of current data reflects what the current relationships would be.

Third, you need to consider the issue of the outpatient here, and within the cost construct of what we include in the cost of the cost reports, we're including the total cost of the residency training program, so it's a training program in terms of the costs of the faculty, the residents' time, and if we're thinking the residents are doing services, some of their time is being spent out in the outpatient facility.

So within this construct for the inpatient payment, because we're talking about the IME for the inpatient payment, do we just take account of the inpatient payment side, or do we somehow throw it all on and pay all this through the inpatient payment, which would be a greater payment, a greater amount of cost, or do we construct something that gives us a payment that goes on outpatient payments as well for that set of costs.

But there's about 20 percent, 25 percent of the residents' time is in the outpatient department of the hospital, and then we're not talking about the other settings where in terms of residents' salary is reflecting those costs.

DR. NEWHOUSE: The issue is outpatient department -- is the difference in product there something we want to pay for?

DR. ROWE: I think that's really an interesting question. I think in many cases -- I mean, it depends on which case you pick. Explain to me again the question. I mean, I think this is really interesting. I just want to make sure I understand the question of the two alternatives as you see it.

MR. LISK: One is how the costs are allocated on the cost reports, but one is what I think Joe was getting at, too, is their value added with the residents' services on the outpatient side.

DR. WILENSKY: What we've argued, Jack, is that the reason we've had this discussion, it's not clear that the costs for the same product are really greater, or at least most of the attempts to try to have measurable sicker patients show up, have not been documented in terms of the attempts to refine the DRG for a severity index.

What we have concluded is rather than being more expensive for the same product, it is that there are additional costs because you are buying a different presumably better product.

DR. NEWHOUSE: At least in the inpatient.

DR. WILENSKY: At least in the inpatient.

DR. ROWE: I understand. The question is, is that true on the outpatient side?

DR. WILENSKY: Yes. The question is, is it different and if it's different, is it something that we think is higher quality or more valuable that we ought to be -- that we want to buy more, buy a more expensive version of

what we get in a non-teaching environment.

DR. ROWE: Wouldn't you take the same kind of analytical approach that you took on the inpatient and sort of continue to use the inpatient as the basis and then do the study to see what the answer is on the outpatient?

DR. WILENSKY: We actually have never done it on the inpatient. We only know it's more expensive and we've presumed it's something worth buying, but we actually have never attempted to get around it.

DR. ROWE: When you said we concluded, you meant you concluded?

DR. WILENSKY: We took the position of we presume that by the actions of Congress there or by the notion, there's a presumption that people are willing to buy this other product and it must be because they think it's better.

DR. ROWE: If I can just follow this for one more second, I think there are a couple categories of activities that occur in the ambulatory setting, and one category that I certainly would feel that the a priori judgment you made would still apply to are those services that used to be in the inpatient setting and have migrated to the outpatient setting.

While that may not be a large portion of the services in the ambulatory setting, it's the most expensive portion. It's the laparoscopic surgery and the arthroscopic surgery and the cardiac catherization and the other things where residents have participated, endoscopy.

So to whatever extent those were covered previously in your judgments about inpatient and they've now migrated to outpatient, they would seem still to be the same kind of thing.

The other question I think deserves discussion. I think it would be interesting to think about it.

MR. MacBAIN: That's one category. There are, I think, at least a couple others. One is one of the quality factors affecting inpatient care in a teaching facility could be state-of-the-art technology that is also used in diagnosing and treating in the outpatient department.

Another could be the cost of excess capacity, however we define that, that's characteristic of a teaching hospital, which gets back to Craig's point. That's an allocation issue of how does the hospital pay for excess capacity and is that appropriately loaded onto the outpatient service, which I think it is since you've got

more and more activity of the hospital as a whole outpatient.

The distinction between in and outpatient I'm not sure really makes a lot of difference in my mind of thinking about what hospitals do. They provide patient care in several different kinds of settings.

DR. LAVE: I think there are some issues here, though. I mean, one of the problems that one gets in an inpatient setting that the residents provide is they are on site making judgments, they're callable, they're over there 24 hours a day. I mean, there is a lot of service, in fact, that they provide.

My understanding is, having watched residents in an outpatient side, is that they are more like -- they don't provide as much of that kind of a function in the outpatient side as they do in the inpatient side.

DR. ROWE: See, this is where I disagree. I would say, if I were an attending physician in the outpatient geriatric service at one of my hospitals, in a given session, which is a half-a-day, I might be able to see, if I were practicing alone doing all the histories and physicals myself and going through with each patient and the family, I

might be able to see ten patients or eight patients.

If I were doing it with two residents, I could see 20 patients. In other words, the point is that through-put is greater, there's greater services provided because it's more efficient because the residents are providing a lot of those services.

DR. LAVE: No, but you're billing for those services. The question is whether or not, in fact, there is something inherently about the quality of each of those 20 services that is different that you want to provide the add-on for. So it's not that -- I mean --

DR. WILENSKY: In some way, it's not a better quality, it's just more through-put, more efficient.

DR. LAVE: You're getting paid for the additional through-put generated by the residents. The question is, is the quality of the product inherently different.

DR. ROWE: I understand.

DR. LAVE: That's what I think is the outpatient. Whereas in the inpatient side, basically the residents are walking the floors.

DR. ROWE: They're doing something that otherwise isn't done and therefore there's value added, is your point.

DR. LAVE: That's right. And if you have a heart attack in the middle of the night, the doctor is right there and everybody is there to take care of you in case of an emergency. I'm not trying to be argumentative.

DR. ROWE: I think it makes sense to me. I just don't know the answer.

MR. JOHNSON: I'm getting a little confused between the difference of just paying for a unit of medical service and how many you're going to do with those and the idea of paying -- if you've got one foot in the water, paying for medical education inpatient, I believe you have the other foot in the water paying for medical education.

DR. WILENSKY: But we're not paying for medical education.

MR. JOHNSON: The service?

DR. NEWHOUSE: No, we're paying for a different product.

DR. WILENSKY: We think we're paying for -- in inpatient we think that the availability and involvement of residents has produced a higher quality product. We don't think that it's clear that it produces a higher quality product in the outpatient. Maybe it does.

MR. JOHNSON: I apologize for using the wrong terminology. I had a senior moment, I guess.

[Laughter.]

MR. JOHNSON: All I was going to say is that I would contend that you do get a higher quality product, I believe, on the outpatient side.

DR. WILENSKY: It's not obvious what you're buying. I'm not sure that we can't make the distinction of saying that we think there is a differential product in the one case but not in the other, but it's definitely not an issue of subsidizing or paying for education in one and not the other.

MR. MacBAIN: There are more characteristics related to high quality in a teaching institution than the presence of residents on the floor at 2:00 in the morning for inpatients. That's part of it, but there's a lot of other stuff going on as well in terms of case mix and equipment and capacity and so on.

MR. LISK: What I want to do is just add what my concept in thinking through this, the added value potentially is in outpatient departments, in particular, let's say even ambulatory training sites are, let's say,

family physician offices in terms of those types of things.

Really it may be that there may be more time spent with the patient with the resident being involved, but also that then there is some other supervising physician in. We have to consider whether what the patient actually gets in the end, is that a really different product.

But in the patient's perspective, there may be some added value there. So some of it is -- in my thinking, some of it was related to time with the patient.

DR. ROWE: I would be interested in an informal survey of the commissioners -- and I have no idea -- I think it's a very interesting question -- as to whether you would rather be seen -- you know, if we had kidney disease and we were going to go see Dr. Lewers if we were lucky enough to be in that situation to see him, if we're unlucky enough to have kidney disease, would we rather be seen by him alone or by him and one of his trainees.

I mean, how do people feel? Do people feel that they're better off? Forgetting who gets paid and what. Do they feel they're better off? Is there value added? Is it better for the patient or is it, in fact, a distraction and not better for the patient?

DR. NEWHOUSE: There's also a difference in setting, when he sees us in the teaching hospital versus the non-teaching hospital.

DR. WILENSKY: I think there's a question of whether -- one of the questions is, if the trade-off is if you were to see Dr. Lewers in a place where there were not potential subsidies, you know you're actually getting his service.

If you are seeing him in a place where there are residents, it may be a flip of a coin as to whether you see him or his resident or much less of his time.

DR. ROWE: But I'm trying to address Judy's issue about I bill all those patients. I've never billed a patient I didn't see, to my knowledge.

DR. NEWHOUSE: Audit averted.

DR. ROWE: You understand what I mean. It's not either the resident or him, but it's him versus him and the resident. Isn't that the question you're asking?

DR. WILENSKY: It may not be for the entire time.

DR. ROWE: Oh, no, I agree with that. In fact, often it's in series. You see the resident first for half-an-hour and then the resident goes and talks to Dr. Lewers

and then you see Dr. Lewers and the resident.

DR. KEMPER: Jack, I'll give you my answer to that question. It's not a fair question given the particular people you used in the comparison, but I would rather go to the medical school not because of being seen by two people, but because I believe that particularly good physicians are attracted to that school, that they're going to be at the leading edge of the field, that if there are new treatments that are going on, they like to be there.

So if I have something routine, I wouldn't want to go there and be seen by two people and wait an extra 45 minutes, but if I had something serious, then I might want that extra human. So I would see that as extra value.

DR. WILENSKY: But is that clear if you went to an outpatient clinic? Would you feel necessarily the same way if you went to the outpatient clinic attached to a teaching hospital as opposed to going into the inpatient setting for more --

DR. KEMPER: I'm saying for the outpatient clinic. Well, the outpatient might be where the diagnosis takes place of a particularly tricky case or where lots of procedures are done where technology matters. I don't know

whether I'm right about that, but I'm saying it's not a matter of just the extra time of the resident.

MR. MacBAIN: Just to follow up on Jack's hypothetical situation and this is looking at it from a non-Medicare population, but commercial and rurals in a couple of different health plans, both of which were based in teaching hospitals, it was not uncommon to have people complain about seeing a resident, even if they saw the staff physician right afterwards. They didn't want to have to go through the whole rigmarole twice.

The patients themselves didn't perceive that as added quality. They wanted the real doctor, in their terminology. So what we're talking about is at a different level than patient perception.

DR. ROWE: That's an answer, too.

DR. NEWHOUSE: I found this discussion interesting because I admit I came in with kind of the Bill MacBain view, but Jack's points about services migrating to state-of-the-art technology, excess capacity, I can certainly imagine cases where those would be useful.

I'm wondering if we need to, at this point, get into the outpatient side. That is, presumably right now the

IME and the DME, the IME at least, is based on inpatient costs. Now, the DME is not. I guess it's the total salary, but if the total salary goes over onto the inpatient side, then at least it's first order of budget neutral.

There's Craig's point about which kind of costs, which we really haven't talked about. Clearly this has to come up if we get to an outpatient PPS, how would we handle teaching institutions with higher costs because they have residents around.

But I wonder if we have to deal with it at this point. I mean, if we talk about the DME, we would have to deal with it if we did an accounting decomposition, I suppose, of direct costs between outpatient and inpatient settings. But if we don't do that, then do we have to deal with it?

MR. MacBAIN: In my mind, I'm trying to come up with something that would be portable to other organizations running residency programs such as Medicare+Choice plans or rural consortia, and if we're going to do that, where we might have a residency program in which the inpatient component is under contract to an entity that doesn't do inpatient care, we've got to have something that's more

portable than --

DR. NEWHOUSE: How can the inpatient portion be under contract to an entity that doesn't do inpatient care?

MR. MacBAIN: I don't know how they would work. I'm not sure what those things would look like, but I'm just trying to think. If a managed care company ends up running a residency program and if they get paid for it, would they be paid only for hospital admissions on a DRG basis? Is that really how we want to fund a residency program?

DR. LAVE: I think we have to think about it the whole way for the following reasons. I think that one of the real problems that the Congress is under and the training programs are under was sort of the concept that the training programs were not consistent with where it was in America, where they wanted American medicine to go, and they felt, in fact, that the way that we paid for GME was not consistent with where we wanted to go.

So I think for us as a commission to come up and say, oh, boy, we've thought about this terrific way of thinking about inpatient payment, the main impact is going to be to redistribute money across facilities and it really doesn't do anything about how we should deal with the major

problems that I think we have.

I think we would look just terribly irresponsible because it does seem to me that the issues that the -- the reports that I read at least have to do with how do we get training money into alternative settings, how do we get training money into the outpatient settings, how do we redesign the training programs so people are more consistently trained.

DR. NEWHOUSE: This was going to happen when we got to the outpatient PPS.

DR. ROWE: I think, Judy --

DR. LAVE: I'm not even your esteemed colleague, anymore.

DR. ROWE: You are still an esteemed colleague, but you're on the border.

[Laughter.]

DR. ROWE: I think, Judy, what you said is true about some of the questions that have been asked and whether or not what you described is what we would do is responsive to it. I think, however, that you're neglecting that one of the questions that was asked is, should direct medical education payment be moved out of the Medicare program and

should it be put into a separate program that would be subject to an annual appropriation.

I think that Joe's formulation and this discussion answers that question very directly and I don't think it would be irresponsible at all. I think, in fact, it would be very responsible to the question and the debate. So I think maybe the questions that you're raising that you've heard we're not addressing, but that doesn't mean we're not addressing any of the important questions.

DR. LAVE: I accept that.

DR. ROWE: Thank you very much. I'd like the record to show that.

MS. ROSENBLATT: I want to add on to the question Jack raised about the outpatient setting. What was running through my mind when you used your example is a branding issue. If the outpatient is connected to the hospital with the name and there's that brand image, it may not, in fact, be a better product, but it's getting the value of the brand name.

MR. JOHNSON: It's late in the day and I'm confused. I'm just trying to understand something about this distinction between inpatient and outpatient and I'll

base that on experience now as my esteemed colleague from New York, or rather Manhattan.

DR. ROWE: We haven't seceded yet.

MR. JOHNSON: There's a situation I'm thinking of. My wife had the temerity to inconvenience everybody a few Christmases ago and break her ankle while decorating the Christmas tree and jumping down from a stool instead of a ladder.

Anyway, we went to the hospital, the orthopod, and we saw this orthopod. We saw him in the hospital, we saw him as an outpatient and all that. The bone was healed and alas, she couldn't walk. Sort of a conundrum.

So we self-referred to a teaching hospital and medical school orthopedic department, went to them, and that surgeon -- it turned out to be a tendon problem in addition to the bone problem -- came with his resident and we saw them first in the outpatient for diagnosis, not connected to the hospital, about 20 miles away in a suburban area.

Saw the surgeon and the resident, both of them were there. She went and had the surgery, both of them were there. She came back from the surgery, went back to see them several times while she was recovering, both of them

were there.

She got certain kinds of explanations from the surgeon and then more explanations and actual service from the resident when the surgeon left the room and whether it was casting or what did he really mean by this and what he said is it will be six months, can I really walk in two weeks, that sort of thing.

But there were two things. There was a definite difference in the service for the similar thing, and it wasn't just inpatient. You know, whether it was the private fee-for-service doctor, you saw him inpatient, you saw him outpatient, you saw him at Kroger -- that's a grocery store -- and whether it was medical school. During this course, you saw people in different settings and they're weren't necessarily --

DR. ROWE: And for some diagnoses, the whole thing would have been outpatient.

MR. JOHNSON: It might have been if it was one of those services Bill was talking about. So I guess I'm having a hard time understanding why there isn't a product there on an outpatient basis that we're not paying for.

DR. NEWHOUSE: Well, that's one of the possible

answers.

MR. LISK: Why don't I go on? The fourth thing under how should direct GME costs be integrated into the IME estimate was the issue of the transition that was brought up in terms of what would need to be considered there.

The second question that we have is, what other revision should be made to the Medicare IME payment, and here we've rephrased really this question is, well, while we have the hood open, what other changes should we make to payment policy that might improve the distribution of payments and affect the level of the indirect medical education adjustment.

So here we have the possibility of considering adopting refined DRGs to measure case mix better, which would have the effect of improving the accuracy of payments while reducing the influence of the resident-to-bed ratio on payments to hospitals.

Second is also the potential issue -- and this gets some more to admissions and whether this is a Medicare payment or a broader payment, but other issues of support for other things that hospitals are involved in with such things as stand-by services and unsponsored research and

those types of things.

Then third, you may also want to consider refining also the IME regression methods and those sort of things, including updating the data so it's more current so you get a more current relationship. So those are the three areas under if you revise the IME estimate.

But also related to that under the third bullet here for the questions of what we'd consider is, what is the appropriate level for the IME adjustment when you get down here, and what would need to be considered when you get here is how you would do this, whether you would reduce to the empirical level or not.

You could implement this policy so aggregate dollars don't change. Empirically, we believe that even after the BBA, the empirical relationship between teaching hospital costs and resident intensity will still be overestimated. So do you want to continue to pay that overestimate.

Second, though, you could bring it down to the empirical level of that relationship. So in aggregate, inpatient payments to teaching hospitals will be reduced if this were done. The payments would more accurately reflect

the cost of providing patient care services to Medicare beneficiaries in those facilities and across all hospitals.

It potentially could also justify paying less than what you find in the empirical relationship if you believe that the costs that are included have been inflated because of how Medicare has paid, in effect, inducing a subsidy and that a lot of these costs are higher then they otherwise really should be in these institutions.

So that is sort of the set of questions that we think need to be considered in revising the IME, and incorporated in here is also those other outpatient issues. So if you adopted this proposal and took some savings from Medicare by either paying based on an empirical relationship between costs and payments or by paying less, some of the savings potentially could be directed to support specific workforce policies since you'd have budget savings in terms of how the policy would be put in place if you wanted to do that, if you thought there was a need for those.

But it would provide some additional funding, could provide some additional funding for doing that if you brought it down to an empirical level or further. But we'll leave that discussion for you for another time when we

discuss workforce issues and those appropriate policies.

DR. NEWHOUSE: Craig, I don't even think we should have that discussion until we know what the empirical level is on updated data with better methods. We don't know that the 5.5 percent is going to wind up above the empirical level because I don't think we really know what the empirical level is at this point.

DR. WILENSKY: I think we just ought to regard them -- presumably at some point --

DR. NEWHOUSE: It's a separable issue.

DR. WILENSKY: It's a separable issue. Whether with a new and better empirical study that relates the costs, it will turn out we are overpaying or underpaying. The empirical analysis will be what it is. The issue that I think we ought to regard as postponing not so much in terms of savings as though there is some amount that we need to put into this, but the justification for having Medicare making these payments is much clearer as sort of a Medicare-appropriate payment.

Whether or not Medicare as opposed to Federal Government ought to have some involvement in workforce, I mean, they are very different kinds of issues and if you

think government can actually either can or should influence the workforce and then the question of if you think it can and it should, how do you want to go about doing that. Then does that have anything to do with Medicare.

So we will have to go through those, but I would like to put that aside from whether or not there's savings, which I think we would want to determine based on an empirical estimate of good current data.

DR. NEWHOUSE: I want to comment on the refined DRGs, which seem unexceptionable to me, but I want to raise a different issue. This is an issue that has bothered me for years. HCFA, when we established PPS, I thought always arbitrarily, if not capriciously, decided that there should be approximately 500 DRGs. Now, I don't think there's a very good substantive reason for that. I mean, the reason was that it would be complex if there were more, but everything just runs ICD-9 through the group, so I don't understand why we can't have more DRGs.

My question is, do we know -- suppose we have 5,000 DRGs. Do we know if that would make any difference in the teaching/non-teaching break?

MR. LISK: Theoretically, if they're able to

capture severity of illness --

DR. NEWHOUSE: No, I know what the theoretical answer is. Has anybody ever tried to look at that?

MR. PETTENGILL: Yes.

DR. NEWHOUSE: The answer is?

MR. PETTENGILL: And the answer is you would capture more of the variation across facilities, including teaching hospitals. The case mix index value would be higher than they now are.

DR. NEWHOUSE: One of the things I think we ought to consider, maybe it's in next year's work plan, would be to go back to the basic design then of the PPS if we're going to talk about refining DRGs and the number of DRGs. Thank you.

DR. LAVE: I have an empirical question in terms of this re-estimation. I think that what we do with the DRGs in re-estimating them is absolutely critical because if it turns out that with the current DRGs that you get, say, a 6.3, whatever it is, with the other costs included in, because I assume we're going to take some of the direct costs and put them in when we re-estimate this, and then, in fact, if we put in the better case mix index and drop down

to 4.3, which one are we going to say is the empirical estimate?

The only way you get the better -- you account for it is if you actually use these DRGs as the basis of --

DR. NEWHOUSE: I'm presuming you would use them.

DR. LAVE: So what you use on the empirical was whether or not you used the payment model to estimate or everything else, and so people have used two different descriptions of the empirical model.

DR. WILENSKY: I assumed, when he raised that that since we use 9,000 CPT codes, we clearly could use more.

DR. LAVE: I just wanted to make sure, that you were going to tie the --

DR. NEWHOUSE: You basically use them now because you write down 7,000 ICD-9 codes. It's just a question of how you map them into DRGs.

DR. WILENSKY: But I assume that if we decided that would be a way to capture some of the variants, we would only make the recommendation if we actually recommended we change the payment.

DR. LAVE: Current payment, you know, is different.

DR. CURRERI: I want to express a concern, I think, that most academic people that are in these teaching programs have and that is that in the case of DME payments in the past which go to the hospital, a certain portion of those DME payments are supposed to go for support of faculty and libraries and that sort of thing.

I'm not saying that almost all of my colleagues, including myself, that have been program directors for years and years, when you go to ask a hospital administrator how is the distribution of these DME payments in my program going, you not only never get an answer, but I'm not sure even if he was willing to answer he would know.

I get a feeling of great distrust right now, if you take all the DME payments and lump them into IME where it goes into a bigger black box which nobody knows how it's spent, that you're going to have some real concern with regard to expanding programs into independent, not hospital owned ambulatory care facilities, particularly in family practice programs, but in other programs as well.

So I think you should be thinking as you do this of what kind of disclosures there should be as to the distribution of these funds because it's really curtailed

the flexibility when you don't know what funds are available as to what kind of contracts you can go out and make with the ambulatory care facilities.

If it all goes into IME, I would like to see some suggestion of reporting requirements to the people who are responsible for contracting out to independent ambulatory care facilities because right now there exists an enormous distrust.

DR. KEMPER: I guess a related question. In terms of establishing new programs, I take it once this is all done, then there's a formula and if somebody wants to establish a new program, the money flows in proportion to the number of residents somehow.

So there's no deterrent to establishing new programs except insofar we have these problems of very different settings that Bill MacBain mentioned like the world cooperatives or health plans or whatever. That's the sort of wrinkle that has to be worked out.

But at least within the hospital and outpatient setting, there's no deterrent to new programs. Is that right?

DR. NEWHOUSE: There's no deterrent now, is there?

DR. KEMPER: No, that's what I'm saying. I think that's a good thing. You want to have that.

DR. ROWE: As somebody who has been a hospital administrator, a program director of a residency program, and a chairman of a department of medicine at various stages in my still early career, let me give you another point of view of how this happens.

The hospital administrator gives the chairman of the department of medicine in a hospital the size of mine, one of mine, $20 million a year as part of his budget. The program director goes into the chairman of medicine and says, where's the money for the residency program? The chairman of medicine sends him to the hospital administrator. You'd better go get it from Jack.

Jack says, I gave the chairman of your department $20 million. It's in there. And so, that's how you go around. Does that sound familiar?

DR. CURRERI: No. I've been both chairman and program director at the same time, so conceivably I'd be arguing with myself I suppose. But the problem is is that in most cases, that is not the case. The budgets come out of the medical school, the payments go to the hospital, and

there isn't supposedly any transfers of money here. I never in 25 years got a single dollar from a hospital that I could identify.

DR. NEWHOUSE: I had a department chairman from one of Jack's competitors at an executive course where I used some of the numbers -- I didn't know he was there -- some of the numbers in our report actually was from his hospital where we listed direct medical education. He said, I just got my money's worth from this course. I've, for 20 years, been trying to get from the hospital administrator what we got and I could never get the number.

[Laughter.]

DR. CURRERI: That's exactly right.

DR. ROWE: And the one thing that that proves and we all knew it is that hospital administrators are smarter than department chairmen.

DR. NEWHOUSE: The cream rises to the top.

MR. LISK: Let's go to the last slide here. There are some other questions that also need to be considered here in terms of concept in integrating this in. One is how the concept can be integrated into other settings, including PPS-excluded hospitals, in terms of them and how this

concept can be integrated there; then as we've already discussed, to the ambulatory training sites, family practice clinics and those types of sites.

Then the second question also concerns -- we've been looking on physician --

DR. ROWE: It wouldn't just be TEFRA hospitals, but it would be TEFRA programs in hospitals.

MR. LISK: No. Actually, they're done based on the DRGs, although those patients -- that actually does raise a good point because on the direct side, it doesn't matter, but on the indirect side it does matter. So it is the TEFRA programs. You're right.

DR. ROWE: It would be the rehab and psych programs in hospitals.

MR. LISK: And the big ones here, too, the places, cancer hospitals have a lot of teaching going on, very involved; pediatrics, although for Medicare, they're not getting much money; but rehab and psych is the other big one and rehab to a little lesser extent.

Again, as I said, the ambulatory training sites --

DR. WILENSKY: What happens in the rehab? Does the money come through the DRG?

DR. NEWHOUSE: They're exempt. But aren't the resident costs in those costs that they're comparing relative to their target?

MR. LISK: No, they're excluded from the target.

DR. LAVE: The indirects are excluded?

MR. LISK: No, the directs are excluded. We're talking about what to deal with those direct costs that are there. We have to deal with those.

DR. NEWHOUSE: To be symmetric, we would just put them in.

MR. LISK: Well, it just is an issue in terms of what specifically -- is that the appropriate way of doing it.

Then finally, as we talked about physicians, is we also need to consider the direct costs for nursing and allied health and what happens there. On the residents side, we have residents and that sort of stuff to account and we don't have that on the nursing and allied health side.

One of the interesting things here, though, is that what's happened over time for a lot of nursing and allied health programs, we used to have diploma programs

which are hospital-based and sponsored. We've moved away from that and there's a lot of B.S. programs that are -- BSN programs that are sponsored by universities, but do go into the hospital setting and other settings.

Those programs have gone on without actually addition of payments. It may be a good reflection of the concepts here, the student pays for the training and they're paying tuition in that setting. They're paying tuition to the program or the school for those cases, but we're going to need to consider what to do on this concept for them.

Physician assistants is another example of a group that has grown, but has paid. There's some clinical aspect to the training that's going on for these students, and so is there any value added again that you'd want to reflect in payments for those types of programs as well.

So that's it for the overheads, and hopefully we can start to, over time, over the next few meetings, come to some closure on some things.

DR. WILENSKY: One of the issues that I'm going to ask you to give me some feedback in either in our meetings or outside the meetings is whether as we continue to talk about the implications of thinking about reimbursement in

this way, whether people are continuing to feel like this is a useful direction to go, including the comments Jack made about the need for a long-term transition if we were to decide to make these changes.

Or whether people continue to feel like this makes more sense from Medicare's point of view as to why we would be making certain kinds of payments or whether you're feeling uncomfortable.

DR. KEMPER: I guess one of the things that I was concerned about in what you wrote, Craig, is the incentive to -- is really the physician supply issue and the incentive to train more physicians and particularly to train more specialists.

So at that level, I have a hard time separating the manpower policy from the payment policy. I don't know if you've thought about that at all or others have thoughts, but that seems a big potential problem with this approach.

MR. LISK: In some concept, I've thought about it a little bit in terms of what this concept means for that, and in some sense, if the value of the residents, of a specialty resident is more to a facility, they'd be willing to pay that resident more.

We've basically gone on an averaging concept, though, so it may make certain types of specialties, if the training actually ends up costing more, less attractive, if we talk about the ambulatory training potentially being more expensive, for instance.

That may be the case where workforce issues come into play, but that might be a case for taking a look outside of this and seeing what programs you might want to have outside of Medicare that would influence that, because that's going to be the case across all payers, not just Medicare, that those types of incentives might be problematic.

That may be the case for how family practice programs were developed, and there are small subsidies to help those programs develop and it could be something similar to those. I mean, that's some of the thinking I've had along those lines.

DR. KEMPER: That would increase the primary care training, but not reduce the specialist training. It may not be different from now, but it's just an area of concern, I guess.

DR. CURRERI: I think we should really revisit the

manpower stuff. I've been reading more and more articles recently saying that the total number of physicians, and with very good I thought numbers, are really just about right now.

Now, there may be a distribution among specialties that's not quite right and there certainly is geographical distribution that's bad, but if we had good geographical distribution into rural areas particularly, we'd have just about the right number of physicians.

It's anybody's guess because this is a very tough field, but I think there is more and more evidence that we're not the 150,000 physicians over what we should be at the present time.

DR. LONG: I'm very careful moving in this general direction. At this end of the day, I'm not thinking too clearly, but I do want to make sure that we -- I'm not sure what the implications of moving in this direction are for the general BBA charge that, you know, we talk about overall federal policy on GME, not just Medicare.

DR. NEWHOUSE: What federal policy on GME?

MR. LISK: The charge was Medicare and other federal policies.

DR. NEWHOUSE: Oh, and other federal policies.

DR. WILENSKY: Let me just respond on that. To the extent we pursue this, it would be in more detail on here is what we think are appropriate Medicare policies and leave open at least, these are questions that may be appropriate for other federal roles, but not Medicare. We don't really have expertise particularly in that area.

I think that the most useful thing we could do would be to distinguish, these are not -- these are not to us obvious Medicare issues, but we wouldn't want to exclude them from being regarded as other government, Federal Government issues. Then basically turn it over to somebody that wants to make those decisions.

DR. CURRERI: I'd like to ask a question which is not clear in my mind and that is, there was an article either today or yesterday in one of the major newspapers quoting the presidents and CEOs of the Harvard hospitals as well as the Stanford hospital saying that although the academic practice plans in these hospitals are in terrible financial shape, the hospitals are looking like they're going to follow in poor financial shape in a matter of time.

My question is, in these payments for graduate

medical education, does Medicare have any system by which they actually know these payments are used for graduate medical education or would the hospitals be free to take this money and meet other financial obligations as they accumulate debt?

DR. ROWE: You can't trace the dollars, but they're based on the fact that the hospitals have higher costs which have been attributable --

DR. NEWHOUSE: They have higher numbers of residents. So some of it goes to pay them.

DR. ROWE: Somebody's paying the residents' salaries, so to that extent --

DR. CURRERI: The salaries are roughly half of what you're getting per resident.

DR. ROWE: A third. A half of what we're getting for the resident and DME is a third of the total of that we're getting for ME.

DR. NEWHOUSE: I just want to respond to a couple of things that were said. One, we may not want to choose to get into this, but if the Congress actually went this route, workforce would have to come up as at least a second order effect because you have these counting rules on how you

treat residents and second residencies and fellows for the purposes of the IRB, which is essentially a workforce-driven consideration and we may or may not want to comment on that.

Second is a response to my esteemed colleague from Alabama. I don't want to really get into the issue of are we training the right number of physicians because I think that the issue is not how things are at the present time, but these are physicians that presumably have a 30 to 40-year lifetime practice, so the question is, well, how many physicians are we going to need over the next 30 to 40 years and that's going to depend on technological change and the willingness to pay for it in ways that we can't, I think, predict. So I would just, I think, leave that moot.

DR. WILENSKY: I took Bill's comment to mean more, it looks like things have sort of sorted themselves out okay anyway and this is another reason. I agree with what you've just said, but I interpreted his comment as meaning that it looks like without our great direction, things are actually sorting themselves out.

DR. CURRERI: The market is working well.

DR. NEWHOUSE: I agree with that general view of the world. At least markets seem to do as well as

government planning, if not better.

DR. WILENSKY: I think people are getting a little worn down, but I did want to -- as I said, to the extent you think about this issue and either feel greater or lesser comfort with the general direction of our thinking, it will be helpful to just register that view.

Obviously if there's a high level of discomfort, you want to go some other direction, then we need to get a sense of that. Otherwise, we're going to presume we're going to continue exploring this path of thinking to help us flesh out what our options and recommendations are.

DR. ROWE: One thing I'd like to say is I think this was a new idea a month ago, at least for all of us but Joe and Craig and Murray's letter I found very helpful. I think there's been a lot of really good, productive, hard thinking about this in the last month on the part of the staff.

The other is, we haven't heard how you feel about this, Gail.

DR. WILENSKY: I'm actually very comfortable with this. The interesting observation was that this is sort of the most classic view for an economist about what would

happen with training. What hadn't happened was to take this a step further of, how should that then view your thinking about this issue.

I am much more comfortable because I've always been more comfortable with IME than DME. DME was always the problem for me, and this puts it in a context in which I have some comfort level. I don't know whether it will mean that we will end up paying more or less. I would like that to be an empirical issue based on better, newer estimates.

DR. ROWE: I see this as a separate issue.

DR. WILENSKY: I do think there are a lot of other issues that to my mind will not be Medicare issues, that if some other part of government wants to take on, that we call workforce issues, that's their welcome job if they wish to do it, but that we can more easily separate out.

There is a legitimate Medicare role, but it's different from what we have sometimes thought about it in terms of this DME/IME. There is a legitimate Medicare role to continue on in this. So I actually have felt much more comfortable.

It will have, I think, appropriate or some desirable redistribution in that it will not be so pegged to

what was a very arbitrary way to calculate a distribution, although I have absolutely no problem with the need to have a very slow transition into whatever the new order is. So I'm pleased in the direction that we're going.

DR. LAVE: I think the only thing is that it really requires a very different way in thinking about it because what we have to think of is that these dollars are all patient care dollars. So every time we think about it, we have to say, these are patient care dollars that are being delivered to pay for things that we want to pay for that the patient is getting that happens to be provided in environments where residents --

DR. NEWHOUSE: The term GME is obviously a problem term.

DR. ROWE: That's why I was trying to come up with that other, supervised care. There needs to be another.

DR. LAVE: Enhanced product, enhanced care.

DR. CURRERI: I think, though, that there -- I was just thinking, somebody asked the question, what enhanced outpatient facilities. Well, I can give you the example of both burn units and trauma units. There is no outpatient therapy outside most of the major teaching hospitals because

they're concentrated because they're high cost/low reimbursement areas, and so the people interested in working at that have to be supported and that's the only outpatient facility you have for specialized care with rehab and so forth.

So there are a lot of places where it's the only outpatient facility, which I think --

DR. LAVE: But what we're really buying, though, is the burn care and we need to pay for the burn care first.

DR. ROWE: The inpatient care.

DR. CURRERI: And the outpatient care.

DR. WILENSKY: Let me see if there are public comments before we close.

MS. WILLIAMS: Deborah Williams, American Hospital Association. Shorter than I think. Good thing Carmela is not here. I think that we appreciate the care the commission has taken with this issue and I'd like to say that as sort of this project develops, I think the AHA is concerned, of course, with supporting the historic mission of teaching hospitals, especially their role in the safety net.

So I think any policy developed in this area

certainly has to have a long transition, so that if there is a need for a mid-course transition or to make changes and develop new policies as you look at its effect upon care that can occur.

The second thing I did want to say is about outpatient. I find it very interesting. This I want to say as a policy analyst. I find it very interesting that when you look at the equations that HCFA has estimated in the rurals, that it's the small rurals that have the higher costs and the large teaching hospitals, but one suspects for different reasons.

Despite the fact that maybe residents allow you to have higher volume in teaching hospitals, they really do have higher costs per service. I'm not sure what that reason is. Maybe when the residents are gone, behind Jack's back, they're opening up extra supply costs and running through the robes, I don't know. But it is at least empirically verifiable. Thank you.

MR. ZECOR: Bob Zecor, Association of American Medical Colleges. Some of those were similar to my comments. I won't repeat them. I did want to comment specifically, though, on the question of do you get a

differential product in the outpatient setting if there is teaching present.

I would argue yes. I think there have been many examples given here, but while it was implicit in your discussion, I think you may want to explicitly discuss the intensity of the teaching. Just as we recognize that the nature of the differential product on the inpatient side is correlated to the intensity of the teaching environment, as represented by the internal resident-to-bed ratio, I think you have a similar phenomena in the outpatient arena.

That is the intensity of the teaching which may well be much greater in hospital-based ambulatory care settings than in other ambulatory care settings. It may lead to a differential product but of different types. Therefore, you have a scaled effect in terms of how differential are those products.

As you deliberate, that may be useful in terms of understanding the spectrum that we're dealing with. Thank you.

MS. HELLER: Karen Heller, Greater New York Hospital Association. Mark Callan and I just had a really interesting sidebar conversation. We had also been feeling

very good about the epiphany in terms of the safety of the money staying in Medicare. However, what does this mean for the managed care carve-out and a premium support model?

I was just presuming all along that, of course, we would continue a carve-out, but Mark was feeling, well, if it's not education. So I think you guys have to deal with that issue as well.

DR. WILENSKY: It's an issue that we've started having some discussion and will continue having with regard to if we were to move to a premium support world, what would this mean given the kind of thinking.

MS. HELLER: Does it just go away now.

MR. GRAEFE: Fred Graefe of Baker & Hostetler on behalf of the American Health Science Education Consortium on behalf of urging you to consider the HMO carve-out for nursing and allied health. As you know, Congress, in the '97 BBA, did it for physicians. It was an oversight not to do it for nursing and allied health.

A bill has been introduced in the house, H.R. 1483, and a similar bill soon in the Senate that will do the same thing for the nursing and allied health pass-through, and as you address these workforce issues, you'll need

nurses and allied health professionals from APNs through PAs and others to meet the 21st century demands. Thank you.

DR. WILENSKY: We will, commissioners, convene again at 7:00 and we will meet tomorrow at 9:00.

[Whereupon, at 5:44 p.m., the meeting recessed, to reconvene at 9:00 a.m., Friday, April 30, 1999.]